DOCTORAL THESIS

Caring towards death

a phenomenological inquiry into the process of becoming and being a hospice nurse

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CARING TOWARDS DEATH:

A PHENOMENOLOGICAL INQUIRY INTO THE PROCESS OF BECOMING AND BEING A HOSPICE NURSE

by

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ABSTRACT

This thesis seeks to illuminate the question of why nurses choose to work with dying patients, with the meanings nurses attribute to their experiences forming the essential material of the study. Adopting a hermeneutic phenomenological perspective, the study involved semi-structured interviews with 30 nurses working in English hospices. The results provide evidence of the ways in which narrative and experience inform one another in an active process of occupational identity formation. Through a search for congruence between ideals and working environments, the nurses had arrived at a point of equilibrium, having identified in hospice a setting in which their nursing ideals could be implemented.

A marked feature of the nurses' accounts was 'dichotomous perception' of the nursing care provided in NHS settings and that provided in hospices, with the dimensions of these contrasts representing ideals embodied in nurse education. Aspects of hospice nursing particularly valued by the nurses were opportunities to provide 'good' nursing care, 'hands-on' nursing, holistic patient care, 'being there' for patients and availability of time.

In the face of conflicts between discourses of nursing care and management discourses focused on cost-effectiveness, these nurses remained uncompromising in their desire to provide 'good' patient care and were, in Maben et al's terms, "sustained idealists". However, the equilibrium they had achieved was perceived by some to be under threat, with financial restrictions and other factors challenging the nurses' identity as hospice nurses.

In developing an understanding of the way in which individuals set their personal narratives in the context of societal factors and engage their dynamic selves in ongoing conversation with themselves and others, the thesis illustrates that, as individuals, we can only make sense of ourselves by taking account of the world around us.

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PART 1

PREPARING FOR A JOURNEY

Chapter 1: The primacy of meaning

Beginnings

Why do nurses choose to work in hospices? This was the question which entered my consciousness at a time in my life when one particular hospice had very special relevance for me. The man I had married when we discovered that he had terminal cancer had been moved from hospital to this hospice. He had been there for just one hour before he died (suddenly and unexpectedly, of a pulmonary embolism). The support I received then, by the hospice nurses and subsequently, by a bereavement counsellor attached to the hospice, was superb. The nurses were able to convey to me their own sense of loss at a time when my own world was falling apart. This unknown man had been delivered into their care and, before they had had a chance to develop a relationship with him, had been snatched from their caring hands. "You must feel cheated" they said, holding me physically and emotionally. "We do as well."

It was only much later, when I came to interview the hospice nurses who co-wrote this thesis, that I understood those words, but a seed was planted at that time - a seed of curiosity which grew as my grieving healed. Why, I wanted to know, would nurses *choose* to work in hospices - in an environment where death is an everyday occurrence? If one of the aims of nursing care is to restore patients to health and active life, what reward could come from seeing one's patients die, not just occasionally, but on an everyday basis?

The question which this thesis addresses first presented itself to me in very simple form and my preconceptions were equally simple. Surely, I thought, people who choose to nurse dying patients must either be selfless, dedicated individuals who feel the pain associated with their constant losses but accept it as part of having a job with meaning, or nurses who can operate at a superficial level, never letting themselves become involved enough to feel the pain of loss - people for whom hospice nursing is just a job.

Later, I became interested in the possibility that there might be a spiritual element in choosing to work in a hospice. If nurses believed that life continued in some form after bodily death, perhaps they would seek out this work as a way to ease the transition of souls into the next world.

My personal experience of death has been largely responsible for my choice of research topic. When my husband died in 1991, my curiosity about hospice nurses readily survived my period of mourning. At that point in my life, Death was already a familiar figure to me. When I was three and a half years old, my father had died in a motorcycle accident, leaving my mother to care for me and my sister, then only six months old. If there was any weeping my mother did her best to ensure that I didn't see it. On the assumption that a child of my age would be unable to grasp the meaning of my father's death, and to spare me the pain of trying to understand it, I was told simply that Daddy wouldn't be coming home any more. This early encounter with Death set a pattern for my life. Apart from my father and my husband, I have lost two older boyfriends, and it has sometimes felt as if the repeating experiences were challenging me to allow myself to express the grief I was unable to work through when my father died.

My initial idea was to write a book dealing with nurses' experiences of hospice work and the ways in which they attempted to protect themselves from the potential meaninglessness and pain of constant deaths. I met the head of the hospice at which my husband had died and subsequently arranged to meet two of the nurses there to talk about my ideas, but when their work commitments prevented this happening I was forced to acknowledge that without the formality of an approved and funded research proposal, I was unlikely (especially as a non-nurse) to be able to gain access to the hospice nurses to whom I wanted to talk.

Other work and interests demanded my attention until reading Christina Mason's book *Journeys into Palliative Care* (2002) reawakened my interest in hospice nurses. In her book, Mason presents eight palliative care workers' accounts of how they came to be working in palliative care, and while these accounts (by individuals including a doctor, a social worker and a nurse) made fascinating reading, I found myself wanting to know a lot more about hospice nurses and their routes into palliative care work.

The notion of undertaking the research as the basis for a doctoral thesis presented itself after I had considered and rejected a number of ideas for doctoral research which had failed to truly inspire me. With the backing of a University Research Degrees Board and the approval of the local NHS

ethics committee, access should be considerably easier to obtain and I would also have the guidance of experienced supervisors.

Focus of the study

The focus of my study is individual hospice nurses' understandings of the process by which they came to be, and continue to work as hospice nurses in English hospices, encompassing the development of their interests in palliative care nursing, self-identified personality traits, values and desired career characteristics and aspects of the social, educational and experiential environment which are identified as having influenced their career paths.

It is nurses' discursive accounts of their experiences, rather than those experiences themselves, which are the primary focus of the research, with the *meanings* nurses attribute to their experiences and the way in which they make sense of their own past lives to construct an identity being seen as the essential material of the study. I believe that, as the researcher, I should be recognised as an essential part of the research process, and two levels of interpretation are involved: the meanings the nurses themselves attach to their experiences and the way in which I, as researcher, interpret these attempts at meaning-construction.

My decision to interview hospice nurses was not based solely on my personal experience of the care they give to patients and relatives but also on their unique position within health care teams caring for those who are dying. Hart (2004:91) observes that caring for dying patients is the "most difficult aspect of nursing". Doctors, says Hart, experience the death of patients in "an entirely different way" from nurses, and are rarely present at the moment it occurs. Even if a doctor *is* present at a patient's death, it is the nurses' job to wash the body and fill its orifices to prevent the leakage of bodily fluids and it is the nurses who have to comfort distressed relatives and friends (ibid). Wright (2002:210-11) notes that, while hospice care is "provided by a team of professionals including nurses, social workers, chaplains, therapists, pharmacists, and home health aides and volunteers" nurses emerge as the "most essential professionals on the hospice team" and hospice care "can be seen primarily as a nursing function".

The decision to interview nurses working in English hospices rather than, for example, nurses caring for dying patients in hospitals, is also based on the fact that hospices are unique in their focus on caring for patients who are terminally ill, so that choosing to work in a hospice may be taken as an indication of commitment to working solely with those for whom death is the only likely outcome (since the 'anomaly' the research seeks to explore and understand is that of nurses choosing to work with the dying, rather than the 'improving' patient).

Aims and objectives

The main aim of the research was to develop an understanding of individuals' understandings of the factors which influenced them to become and to continue to work as hospice nurses. Specific objectives were:

- To develop an understanding of individuals' understanding of the various influences (including social, educational and experiential) which are perceived to have led them to become hospice nurses, with particular emphasis on early experiences of caring/health problems/bereavement and spiritual/religious values

- To develop an understanding of perceived patterns of interaction between the various factors influencing individuals to become hospice nurses

- To develop an understanding of the factors influencing individuals to continue to work as hospice nurses

- To investigate the relationship between perceptions, motives and personal stories as they influence the process of becoming and being a hospice nurse

- To examine notions of 'caring' and 'curing', with special reference to the distinction between 'caring for life' and 'caring towards death'.

Research questions

Questions which I hoped it would be possible to answer from the research related to the influence of events, individual values and individual perceptions on nurses' choices of life path:

- Are experiences of caring for others, personal health problems or bereavement seen as influential in bringing people to work as hospice nurses (as suggested by Mason 2002)?

- What are the perceived patterns of interaction between the factors that influence people to become hospice nurses (for example, are some types of influence accorded primacy over others?)

- Is there any alignment between broad understanding of 'life purpose'/spiritual or religious values and choice of hospice work?

- Does 'caring towards death' (rather than 'caring for life') come to be accorded a positive value, and if so, in what way?

- What are the features of hospice work that attract nurses and encourage them to continue in this work?

- In what ways do individuals' perceptions, motives and personal stories interact and influence one another in the process of becoming and being a hospice nurse?

I was concerned to distinguish between *perceptions* of what working in hospice care and other specialties might involve, *motives* in terms of what individuals are hoping to achieve by making a particular choice, and the ways in which individuals construct their own meanings as a way of making sense of their experience and relate their current position to a meaningful past. It seemed to me to be likely that these three aspects of career choice would turn out to be inter-related, but when I began my research there were no studies which had explored the ways in which they interacted and influenced one another. The use of a hermeneutic phenomenological approach, I felt, offered considerable potential for an exploration of this uncharted area.

Towards explanation or understanding?

Ricoeur (1976:72) distinguishes between understanding and explanation, which he identifies as "a clearly contrasting duality in Romanticist hermeneutics". Explanation, he observes, finds its "paradigmatic" field of application in the natural sciences. "When there are external facts to observe, hypotheses to be submitted to empirical verification, general laws for covering such facts, theories to encompass the scattered laws in a systematic whole, and subordination of empirical generalizations to hypothetic-deductive procedures, then we may say that we 'explain'." Understanding, in contrast, "finds its originary field of application in the human sciences (the German *Geistwissenschaften*), where science has to do with the experience of other subjects or other minds similar to our own" (ibid).

Steedman observes that other writers such as Dilthey have similarly drawn attention to the fact that the natural sciences traditionally sought explanation, while the human sciences sought meaning. More recently, however, philosophers of science have become more tentative about natural science's claims to objectivity and the attempt to provide demarcation criteria to distinguish scientific knowledge from other sorts of knowledge "has proven impossible to defend..." (Steedman 1991:56).

Following Gadamer, whose approach to research was to develop a deeper understanding of a phenomenon (Gadamer 1990) my aim was to develop an *understanding* of how nurses construct their journeys into hospice work in the light of their lives as a whole. I hoped to use the nurses' understandings of their life journeys to cast light on the *process* of becoming and being a hospice nurse. The research would involve two levels of 'meaning making' insofar as I, as researcher, would be attempting to interpret my respondents' understandings of their own life journeys, and I hoped that this process would cast light on a previously unresearched area. When I designed the research, I did not dismiss the possibility that my understanding might lead towards tentative 'explanation' but the primary aim was always the development of understanding.

How does the research contribute to the existing knowledge base?

The study represented a search for new knowledge which might have implications for both hospice nurses and their patients (although this was not the primary reason for undertaking the research). I felt that a better understanding of what leads individuals into working in hospice care might better enable employers to maximise hospice nurses' job satisfaction and thereby maximise quality of care for patients. Since this would be essentially an exploratory piece of research which would cover ground not previously explored in depth, I hoped that it would also provide a platform for further research of interest to sociologists in a number of sub-disciplines. It would develop an empirical basis for further theorising within the *sociology of emotions* (contributing, in particular, to the growing literature on emotional labour). The *sociology of health and illness* might benefit from insight into the effects of existing organisation of care arrangements in terms of recruitment of professional carers. The research, I hoped, would also contribute strongly to theorising in the *sociology of death and dying* (a sub-discipline in which there is increasing academic interest). In exploring what draws people to work with those with terminal illness, it would help to illuminate attitudes to death and dying in contemporary society.

Structure of the thesis

This thesis describes a journey - my own journey of discovery. The hospice nurses whose words I have used to search for answers to my questions led me on a unique and fascinating quest, whose treasure was not at all what I had expected it to be. I am deeply indebted to these caring individuals who took the time to share their experiences with me.

In Chapter 2, I review the literature relevant to my research, placing it in context and identifying a gap in the literature which indicates a need for further research. Chapter 3 discusses the methodological and philosophical approach I adopted for my research. In Chapter 4 I discuss the way in which I gained access to the participating hospices and contacted potential interviewees, ethical issues (including the process of ethical clearance), development of my interview topic guide, my pilot study, conducting the interviews, where interviews took place and the implications of this, my method of data analysis, my role as 'co-producer' of data, the recording and transcribing of interviews and the extent to which interviewees were able to comment on my findings. Chapters 5

through 10 draw on the recollections and reflections of my 30 respondents, following them through their narratives from the time when they made a decision to become nurses to their present roles as hospice nurses. In Chapter 11, I present my conclusions and suggest what implications these might have for the nursing profession as a whole and for hospices in particular. I draw attention to the important role of self-narrative in the formation and enactment of identity and suggest areas which could benefit from further research.

Chapter 2: Setting the context: Previous research on choice of nursing as a career

Introduction

In this chapter, I set my research in context by examining previous work on choice of nursing as a career and what is known about how and why nurses choose to work in different nursing specialties on qualification. I identify the limitations of previous research and make the case for further research on nurses' paths into hospice work. Sources of information for this chapter are detailed in Appendix 1.

Images of nursing

Studies of public images of nursing have repeatedly shown that, while nurses may be admired by the public, nursing is regarded as a low status profession (Brindle 2004; Kohler and Edwards 1990; De Vries 2000; Rossiter et al 1999; Whitehead et al 2007). De Vries (2000: 26) observes that most studies indicate that members of the public have a poor image of nursing and the mass media have undoubtedly contributed to nursing's image as a predominantly female, poorly-paid occupation (Kalisch and Kalisch 1983a/1983b; Salvage 1985; Hemsley-Brown and Foskett 1999; Seago et al 2006; Whitehead et al 2007; Cohen et al 2004; May et al 1991; Stevens and Walker 1993).

The persistence of negative images of nursing has social implications. Kalisch and Kalisch (1983b) observe "Since public opinion is vital to success of social, political and professional groups in attaining their goals, these images distort the public's concept of nursing and reinforce an outmoded legacy of beliefs, expectations and myths about nursing." (Kalisch and Kalisch 1983b:850). Bridges notes that images will affect the decisions of politicians and policymakers when allocating health care resources (Bridges 1990:48). Negative popular images of nursing are also likely to have effects on nurses themselves (Bridges 1990; Kalisch and Kalisch 1983b; Spouse 2000). Kalisch and Kalisch suggest that negative portrayals of nurses "affect nurses' self-images and undermine nurses' self-confidence, beliefs and values "(Kalisch and Kalisch 1993b). Spouse (2000) found that nursing students' perceptions of nursing had a profound effect on their decision whether to continue with their course or to leave nursing. Perhaps the most important effect of

negative images of nursing is exerted on young people choosing careers. Much research has been undertaken (especially in the USA) on the ways in which nursing is perceived by school students and the reasons why nursing is or is not chosen as a potential career. Twenty six years ago, Kalisch and Kalisch observed that negative images of nursing exerted an effect on the quality and number of people who choose a nursing career, which they saw as a particular cause for concern at a time when young women were increasingly choosing to enter traditional male fields of work (Kalisch and Kalisch 1983b).

The mass media have been identified as particularly powerful creators and perpetuators of images of nursing. In the 1980s, Kalisch and Kalisch undertook a study of images of nursing in the mass media, which they saw as "instrumental in the image formation process" (1983a:3). Public opinion polls, they argued, revealed that most of the new orientations and beliefs that adults acquire during their lifetime are based on information supplied by the mass media. "People do not necessarily adopt the precise attitudes and opinions that may be suggested by the media" they argue, "but the information provides the ingredients they use to adjust to the existing attitudes and opinions to keep pace with a changing world. One must therefore credit the mass media with a sizeable share of continuing socialization and resocialization about all aspects of life including nurses and nursing." (Kalisch and Kalisch 1983a:4). More recently, the BBC Radio 4 programme 'You and Yours' observed that the media were to blame for publicity on 'bad nurses' "because nurses sell newspapers" (BBC 2007). Kiger (1993) in a study of changes in the images of nursing held by nursing students over their training, found that "[t]he images revealed in students' initial accounts seemed to consist of a mixture of what they retained from childhood, what they had seen on television, and what they had encountered in personal past experience" (Kiger 1993:311). Mitchell, in a study of the way in which women in the UK "became" nurses, found that the nursing students she spoke to "viewed nursing through the lens of the media and they viewed it the way their parents told them it used to be. They appear to have chosen not to heed what the information leaflets say... They prefer to believe what appears familiar to them, that is the traditional portrayal of nursing and nurse education." (Mitchell 2002:144)

Choice of nursing as a career

Perhaps not surprisingly, given the concern in many countries about recruitment to nursing, a considerable amount of research has been conducted on the factors affecting choice of nursing as a career. Table 1 shows some of the main studies which have considered this issue.

Table 1: ***Studies of factors in choice of nursing as a career***

Date	Author/s	Country	Description	Sample	Data Collection	Data Analysis
1983	Moores et al	UK (England)	Factors affecting nurses' decisions to enter, stay in, leave or re-enter nursing	2,325 qualified female nurses	Questionnaire (closed questions)	Frequencies/ Statistical analysis
1986	Adejunmobi	Nigeria	Socio-demographic characteristics / opinions of nursing students (including reasons for choice)	293 nursing students	Questionnaire	Frequencies/ Cross-tabulation
1989	Grossman et al	USA	High school students' perceptions of nursing as a career (including effect of nursing role models)	300 high school junior students	Questionnaire	Opinion scores/ Statistical analysis
1990	Murray & Chambers	UK (Northern Ireland)	Characteristics of students entering different types of nurse training	27 registered nurses / 41 nursing degree students/ 46 students at nursing college	Questionnaire	Frequencies/ Statistical analysis
1991	Kerston et al	USA	Motivating factors in nursing students' choice of nursing as career	752 nursing students	Questionnaire	Frequencies/ Categorisation of qualitative data
1993	Kiger	UK (Scotland)	Student nurses' images of nursing from entry to training to early clinical experiences (including sources of images)	24 nursing students	3 rounds of informal interviews	Themes / Categories (qualitative)
1993	Stevens & Walker	USA	High school seniors' reasons for choice/ non-choice of nursing as a career	641 college-bound high school seniors	Questionnaire including Likert scale & closed questions	Frequencies / Cross-tabulations/ Statistical analysis
1995	Murrells et al	UK (England)	Sources of information, influence & encouragement in deciding to pursue nurse education	1,164 registered general nurses (shortly after qualification)	Questionnaire	Frequencies
1996	Barriball & While	UK (England)	Comparison of nurses who chose nursing in childhood / nurses who chose later (including reasons for choice)	449 qualified & unqualified nurses (data from only 422 reported)	Semi-structured interview	Quantitative / Statistical analysis
1997	Williams et al	Canada	Nursing students' reasons for choosing nursing	626 nursing students	Questionnaire including open-ended questions	Content analysis / Categorisation
1997	Collings	UK (England)	2 surveys of nursing students / qualified nurses to explore why	Survey 1: 300 nursing students	Occupational rating scale completed in	Comparison of occupational values profiles

			they became nurses	/ Survey 2: 168 nursing students & 46 qualified nurses	relation to ideal job	1980 & 1996
1999	Hemsley-Brown & Foskett	UK (England)	School students' perceptions of nursing as a career (including reasons why would be interested)	410 school students	Focus groups	Analysis of focus group data
2000	Beck	USA	The meaning of students' experiences in choosing nursing as a career	27 nursing students	Written accounts	Phenomenological analysis (Colaizzi's method)
2006	Grainger & Bolan	Canada	Nursing students' perceptions of nursing	213 1st year & 150 4th year nursing students	Nursing attitude questionnaire & nursing orientation tool	Quantitative / statistical analysis
2007	Whitehead et al	UK (England)	Why school students do / do not choose nursing as a career	106 school students (age 16 and over)	Questionnaire	Frequencies / Thematic analysis

Types of evidence available

The evidence in this area comes from a number of sources:

Attributions of motivation

It is common for writers on nursing (particularly in the press) to refer to assumed motivations of individuals who choose to become nurses. Most frequently, readers are assured that individuals become nurses because they "want to help people", with this assumption sometimes being advanced in discussions of the ways in which today's NHS makes it 'difficult for nurses to care'. Speaking on a recent BBC Radio 4 programme, Howard Catten, head of policy at the Royal College of Nursing, said that people go into nursing "because they want to care." "That" he said "has been the primary motivator and it will remain the primary motivator... Time and again we hear from nurses that they go into nursing because they want to care. That always *has* been the primary motivator, and it will *stay* the primary motivator." (BBC 2007)

Evidence from research taking a different primary focus

Some evidence on the factors involved in choice of nursing as a career comes from studies which have not specifically set out to examine the reasons why individuals decide to become nurses but which nevertheless do throw some light on this question. An example of such research is Murray and Chambers' (1990) Northern Ireland study of the characteristics of individuals entering different types of nurse training. This study included an exploration of individuals' reasons for choosing

nursing as a career and found that a desire to "help people" and a desire for job satisfaction ranked highly as reasons for entering nurse training, and that other nurses had been particularly influential in encouraging respondents to become nurses.

Another example of this sort of evidence is Kiger's (1993) Scottish study of students' images of nursing. Three rounds of interviews were held with 24 nursing students with the aim of identifying characteristics of the nursing images held by students as they embarked on nurse training and discovering what happened to these images once students encountered the 'real world' of nursing and the processes involved in the development of images from their initial to their experience-mediated forms. In examining the images nursing students held of nursing, Kiger was able to identify some of the factors which had drawn them into nurse education, including a desire to work with people in a helping relationship and a desire for an occupation which individuals felt was "not just a job ", which was respected and which offered prospects for promotion and specialisation.

Prospective studies of school students' perceptions of nursing

A large number of studies has been conducted (primarily in the USA) of school students' perceptions of nursing as a career (May et al 1991; Grossman et al 1989; Hemsley-Brown and Foskett 1999; Kohler and Edwards 1990; Mendez and Louis 1991; Rossiter et al 1999; Seago et al 2006; Kersten et al 1991; Whitehead et al 2007). Hemsley-Brown and Foskett (1999) examined UK students' perceptions of nursing as a career at a number of key stages in their education and decision making and how these perceptions influenced their subsequent career decisions. Findings from the study indicated that although young people expressed admiration for the work of nurses, this was rarely matched by an envy of nurses or a desire to become a nurse themselves. While nursing was considered a 'female' occupation, engineering was identified as suitable for males, and the 'invisibility' of the knowledge and decision-making components of nursing practice "contributed towards the perceived lack of status" (Hemsley-Brown and Foskett 1999:1348). The main reason given by those students who did express interest in nursing was a wish to be involved with 'helping others'.

Whitehead et al (2007) looked at career choices made by potential UK student nurses, using a questionnaire given to 16-year-old students. The students primarily perceived nursing to be about

'caring for people', 'making people well' and 'helping people', but knowledge of the required qualifications was low and the majority were not interested in nursing as a career. Boys were especially likely to reject the idea of nursing and despite recent changes in pay and occupational structure, respondents still perceived nursing as a badly paid profession. In general, respondents were found to have "a very limited view of nursing" (Whitehead et al 2007:495) and nursing's perceived low status and stereotypical assumptions that nursing was 'women's work' were found to "limit [nursing's] potential as a career choice for young people in this study" (ibid.). Those who were interested in nursing as a career were all female and the reasons given for interest "seemed to be broadly related to liking working with people and helping them" (ibid.).

Stevens and Walker (1993) undertook a study of 641 USA high-school seniors to determine why nursing was or was not selected as a career. Overall knowledge of nursing was fairly accurate, but only half knew about typical nursing salaries and fewer were aware of work hours and the students were relatively uninformed about the roles and tasks of nurses. Overall, opinions of nursing were favourable but only half believed that nurses had many opportunities for promotion or thought nurses could "always get a job" and only a third believed nursing to be a prestigious occupation. Almost half believed that nursing was mainly women's work. Reasons given for not choosing nursing were (in order of numbers stating them) salary (50.9%), dislike of sick people (47.3%), hours (40.9%), a perception of nursing as unpleasant work (40.5%), dislike of blood (37.8%), dislike of waiting on people (24.3%), the setting (20.4%) and a perception of nursing as being 'not important work' (6.7%).

Studies of comparisons made by school students between 'ideal' careers and nursing

A variation on the 'perceptions' type of study has been used in the USA, asking school students to visualise their 'ideal' career and compare the components of this 'ideal' with their perceptions of nursing (Marriner-Tomey et al 1990; Mendez and Louis 1991; Marriner-Tomey et al 1996; Cohen et al 2004; Degazon and Shaw 2007). Cohen et al (2004) sought 301 middle school students' perceptions of an ideal career and a career in nursing and found that nursing was seen as not providing as much autonomy or respect as the students' 'ideal' careers and also as having less decision-making potential and being more 'hands-on' than an 'ideal' career.

Degazon and Shaw (2007), in a study of 114 high school students, found that they perceived an 'ideal' career as having more power, more positive evaluation and as being less active than a career in nursing would offer. Areas of greatest disparity and those that showed nursing least favourably were making decisions for oneself, always having a job, working in a safe place, making a lot of money and earning appreciation and respect.

'Retrospective' studies of nurses/nursing students

While 'prospective' studies have looked at individuals who are or are not interested in nursing as a career, 'retrospective' studies of nurses or nursing students have asked individuals who have made the decision to embark on nurse training why they made this decision. Moores et al (1983) as part of a wider study concerned with changing nursing employment patterns, gave a questionnaire to 2,325 qualified female nurses (some were working as nurses, some were working in other occupations and others were no longer working). They report on two surveys separated by four years, in which women who had qualified as nurses were asked questions concerning the factors which influenced their choice of nursing (and, where relevant, why they had left nursing and what might have encouraged them to return).

Murrells et al (1995) gave questionnaires to 1,164 registered general nurses in England shortly after qualification as part of a longitudinal study commissioned by the Department of Health in response to concerns about attrition from the nursing workforce, to "gain an understanding of the decision to pursue nurse education, of nurses' plans at qualification and subsequent career development, and the factors that facilitate or constrain the translation of plans into action and affect the likelihood of retention in the service" (1995:398). Barriball and While's (1996) UK study compared individuals who had selected nursing as a career in childhood with individuals who had chosen later in life, examining the reasons given for choosing nursing. Collings (1997) reports on two surveys undertaken in 1980 and 1996 which examined the reasons given by qualified nurses and nursing students for having chosen nursing. In the 1980 survey, nursing students were asked to rate each of Rosenberg's ten occupational values in terms of their importance in an ideal job, and in 1996, qualified nurses and nursing students were asked similar questions to those used in the earlier survey. Like their counterparts in 1980, the 1996 nursing students were found to be

"particularly motivated by people-oriented activities in their work". Job security and stability, and opportunities to use one's special abilities were also important to the students. Extrinsic motivators, such as earnings and having status and prestige were reported not to have been rated so highly. "People-oriented values" Collings suggested, "still appear to be paramount in attracting people to nursing." (1997:54)

Each of these types of study has its limitations, and these are discussed below. A wide variety of study designs and methods have been used, including questionnaires with closed questions, focus groups and interviews (see Table 2) but there has been relatively little qualitative work in this area to explore the complexities of influence on choice of nursing as a career.

A desire to help or to care for people has emerged as a primary motivating factor in choice of nursing as a career regardless of the methodological approach used or the country in which the research was undertaken (Adejunmobi 1986; Barriball and While 1996; Beck 2000; Stevens and Walker 1993; Collings 1997; Day et al 1995; Rognstad et al 2002/2004; Grainger and Bolan 2006; Hemsley-Brown and Foskett 1999; Kersten et al 1991; Kiger 1993; Murray and Chambers 1990; Whitehead et al 2007; Williams et al 1997). Other factors which have been identified as influencing choice of nursing as a career have included: a desire to fulfil psychological/emotional needs, a desire to work with people or to 'make a difference', personal experience of illness or hospitalisation, the influence of parents, family and close friends and pragmatic factors such as career stability (for further details see Appendix 2).

Choice of specialty

While a considerable amount of research has been undertaken, both in the UK and in other countries, on the factors involved in choice of nursing as a career, less attention has been paid to the choices nurses make on qualification regarding the nursing specialties on which they will focus (Fenush and Hupcey 2008; Happell 1999; Mackintosh 2007; Marsland and Hickey 2003). An understanding of the way in which nurses make these decisions is important for recruitment into individual specialties, as the research which has been undertaken in this area suggests that some nursing specialties are considerably more popular than others. Happell (1999:500) observes "If the nursing profession aims to produce nurses to meet the health care needs of the wider community,

it is essential to understand the reasons why some areas of practice are viewed positively whilst others are not." Table 2 provides information on the main studies reviewed here.

Table 2: ***Studies of factors in choice of nursing specialty***

Date	Author/s	Country	Description	Sample	Data Collection	Data Analysis
1994	Kalideen	UK	Exploration of factors affecting nurses' choice of theatre nursing	15 theatre nurses	Interviews	Qualitative analysis using constant comparative method
1996	Moir & Abraham	UK (Scotland)	Choice of psychiatric nursing by undergraduate nursing students: constructing an identity through contrasts with general nursing	10 entrant & 10 final year nursing students (paper reports on six final-year students)	In-depth interviews	Qualitative analysis of interview data
1997	Heskins	UK (England)	Perceptions of intensive care nurses of their work (including reasons for choice)	14 intensive care nurses	Interviews	Thematic content analysis
1999	White	UK (Wales)	Impact of clinical experiences during nurse training on initial career choice	47 pre-registration adult branch nursing students	Questionnaires and focus groups	Analysis of questionnaire and focus group data
1999	Happell	Australia	Study of where undergraduate student nurses want to work after graduation	793 nursing students	Questionnaires	Frequencies
2003	Marsland & Hickey	UK (England)	Effect of nurse training on job plans	1,596 adult branch nurses	Questionnaires	Frequencies and statistical analysis
2007	Mackintosh	UK (England)	Registered nurses' reasons for working in surgical areas	16 nurses working in surgical areas	Semi-structured interviews	Qualitative analysis
2008	Fenush & Hupcey	USA	Clinical unit choices of graduating nursing students	55 senior baccalaureate nurses	Semi-structured focus groups	Qualitative analysis of focus group data

Choice of specialty may be affected by a wide range of factors including personal preferences for client group, personality, previous life experiences, the effects of nurse training, the influence of role models and fellow students, and images of individual specialties as well as pragmatic considerations such as working environment, convenience and availability of employment opportunities (Fenush and Hupcey 2008; Mackintosh 2007; Payne et al 1998; White 1999). Mackintosh (2007: 1134) suggests that nurses select specialties in which to work according to their "different professional perspectives on the purpose of nursing work" while Melia (1987) draws attention to the fact that the nursing students in her study differentiated between work which they saw as constituting "real nursing" and that which they saw as "not really nursing." The criteria the students used to distinguish "real" nursing from "not really nursing" varied "according to

circumstances, social and situational " (1987:134) but included patient characteristics such as age and severity of illness, location of the patient in terms of the area of medical specialty, the 'pace' of work and the level of technology involved (Melia 1987).

The students in Melia's study preferred work which was more technical, fast-moving and medically-dominated, contrasting wards with these characteristics with slow-moving geriatric wards, where patients were less likely to create 'rewards' for the nurses by recovering sufficiently to be sent home. Melia suggests that, in distinguishing between "real nursing" and "not really nursing" her student nurses were taking their lead from the medical profession: "The students in this study" she writes "expressed interest in the technical aspects of their work, placing a greater importance on the medical knowledge, rather than on the 'nursing' they were taught. In short, they succumbed to medical dominance" (1987:179).

Happell (1999) draws on the work of Stevens and Crouch (1995) which suggests that students are strongly socialised into accepting the care/cure dichotomy, so that the most desirable areas of nursing are those which have the clear aim of curing illness and saving lives. Happell notes that, in striving for recognition as a profession, nursing has tended to emphasise the importance of technical skills over the caring aspect of the nursing role (1999: 503). Exploring images of nursing held by Scottish nursing students, Happell found that a consistent theme in the students' view of nursing was that the medical-surgical environment represented "real" nursing. Nurses entered training with this conception of nursing and nothing they encountered in their training was effective in altering this conception: "... students tend to graduate from nursing programs with an unchanged, perhaps even confirmed view, that medical-surgical nursing most accurately represents the profession" (Happell 1999:504). Given that the rewards gained from seeing patients recover and go home appear to be sought after by nurses (Gaydos 2004; Mackintosh 2007; Rognstad et al 2004) it is not surprising that most nurses work in cure-oriented specialties (Barnard et al 2006).

Festinger's concept of 'cognitive dissonance' (Festinger 1957) has been little explored in studies of nursing (Mackintosh 2007) but could, I suggest, be a useful concept to invoke in an attempt to understand why nurses shun some areas of work and prefer others. Several writers have noted a

tendency for nurses to avoid areas of nursing which are perceived as stressful or in other ways undesirable (Mackintosh 2007; Fenush and Hupcey 2008; White 1999). White (1999) suggests that if a specialty does not match their expectations, images and preferences, nurses will not seek a job in that specialty, while Moir and Abraham (1996) suggest that students choose their nursing specialty by comparing their own identities with the image presented by that specialty.

The impact of nurse training on choice of specialty

While some research does suggest that nurses enter training with a clear idea of the specialty in which they would like to work once qualified (Happell 1999) there is a fairly clear consensus in the UK literature that nurse training exerts a strong influence on nurses' decisions on where they will work (Marsland and Hickey 2003; Pearcey and Elliott 2004). It is not clear which aspects of training have the most effect on choice of specialty, but the influence of specific members of nursing staff and experiences of student placements on wards appear to be particularly influential (Fenush and Hupcey 2008; Marsland and Hickey 2003; Pearcey and Elliott 2004). Marsland and Hickey (2003) found that course experiences were more likely to encourage than to discourage nursing students from wanting to work in a particular specialty, although for three specialties (elderly care, outpatients' and theatres) respondents were significantly more likely to be discouraged than encouraged (2003:226). Kalideen (1994) found that all the respondents in her study of theatre nurses had developed an interest in theatres as a possible career through an initial course allocation while White (1999) reported that contact with elderly and mentally handicapped patients led to more positive attitudes among nursing students. White (1999:157) found that nursing students appeared to use "preconceived images and expectations about nursing on which they relied for job selection "unless changed by personal experience during their courses".

Preferences for different nursing specialties

Fenush and Hupcey (2008) in an American study, found that approximately one third of graduating nursing students had opted for **paediatrics**, with half of these choosing paediatric critical care. In Australia, Happell (1999) found that working with children and babies and in areas of nursing involving high levels of technology were perceived as "significantly more desirable to beginning nurses than areas of nursing practice involving working with elderly people, the mentally ill and within community settings". In Happell's study, formal or informal experience of working with

children and a belief that nurses had the necessary skills for this work were cited as reasons for choosing work with children. A love of babies and children, experience of and interest in and/or a desire to experience childbirth, and a perception of the work as 'rewarding' were given as an explanation for choice of midwifery.

Several studies have found that **intensive (or critical) care** is a popular specialty among nurses. Fenush and Hupcey (2008) in an American study found that critical care was chosen over working in general medical or surgical units "because of the high patient acuity, challenges, the pace of the intensive care or emergency department, the smaller patient-nurse ratio, independence, and the perception of '... making a big difference in the care of a patient'" (2008:93). Happell (1999) in an Australian study, found that attractive aspects of intensive/critical care were the fact that it was perceived as exciting, challenging and interesting, with high levels of action and technology.

Heskins (1997) in a small English study, found that the most common reason for liking intensive care work was the fact that it afforded nurses an opportunity to nurse patients on a one-to-one basis. "Most nurses compared the ICU environment to wards, feeling that ward nursing was too rushed, and identified that in ICU there was enough time to look after patients as they wished, in contrast to the needs-led service on the wards" (1997:68). Here, a focus on 'whole person' nursing and the inclusion of relatives in patient care appeared to be more of an attraction than the technology involved. "Staff placed considerable value on being able to nurse as they wished, achieving satisfaction at the end of the shift arose several times. There was also an element of control involved, in relation to controlling one's own work during the shift." (ibid)

Mackintosh, in an English qualitative study of registered nurses' reasons for working in **surgical** areas, found that surgery was chosen for its fast pace and patient turnover and its use of technology, and because nurses found it rewarding when patients made a successful recovery from their operations. "These findings" argues Mackintosh "suggest that participants actively chose to work with ' healthy' patients in preference to those who may be considered 'ill', and this is closely linked to the identified need of participants to be able to 'make patients better'" (Mackintosh 2007:1134). Melia (1987) found that some of the students in her study expressed a liking for 'being busy' as distinct from 'looking busy'. "Surgical wards were often preferred to medical wards on the

grounds that they were more exciting, had a faster patient turnover, and ran at a quicker pace." (1987:47). A respondent in Pearcey and Elliott's (2004) study of 14 English nursing students said that she had "heard nurses say that they much prefer [wards where there is a high patient turnover] because they have a very short space of time where they get to know a person... they're not there long enough to annoy them, so they have a good relationship." (2004:384). This student compared this situation with caring for elderly patients on general wards who were " there week after week usually and it is quite a stressful job being a nurse" (ibid). Pearcey and Elliott comment "... quite alarmingly some students had picked up some very negative attitudes towards longer stay patients" (ibid).

Aspects of medical and/or surgical nursing found to discourage nurses from applying for work in these areas include the fact that these areas are seen as stressful because of the high numbers of patients, too "slow", too "boring " and "mundane". Fenush and Hupcey found that medical/surgical nurses were viewed as "always busy because of the high [sic] nurse-patient ratio" but these units were also described as "mundane" and "boring". "These contradictory perceptions" observe Fenush and Hupcey "appear to have an impact in a student's initial career choice." (2008:94). Mackintosh (2007) found that surgery was selected over medicine with medicine being regarded as more distressing because of the nature of medical conditions medical patients experienced and especially because medical patients were "perceived to make little progress towards recovery" (2007:1138).

Happell's Australian study (1999) found that **operating theatre** work was one of the more highly favoured areas of nursing, with its attractiveness being related to the challenging, interesting and exciting atmosphere nursing students believed to be linked with this work and also to an interest in technology and surgery and a desire for a high level of responsibility and opportunity to work as a team. Other research, however, has found that theatre nursing is not a popular option for nursing students. Marsland and Hickey's (2003) UK study found that nurse training tended to discourage nurses from going into this specialty, with theatre work being one of the specialties (along with elderly care and outpatients') perceived negatively. White (1999) also found negative images of theatre work in her Welsh study, with nurses having had little opportunity to test out their images while in training. Low levels of patient contact, a subservient relationship with surgeons, anxiety

about instrumentation and a dislike of the working environment were cited as reasons for lack of interest in this area of work.

Several research studies have concluded that, in general, nurses are not attracted to working with **older people** (Happell 1999; Mackintosh 2007; Marsland and Hickey 2003; Melia 1987; Pearcey and Elliott 2004). Happell (1999) found in an Australian study that working with elderly people was ranked last in order of preference by nursing students who cited a negative view of the clientele or the working environment, or their own previous experience as reasons for not wanting to enter this area of work. Mackintosh (2007) in an English study, found that students and qualified nurses tended to reject future career plans to work with chronically ill, long-stay patients "in favour of working with groups of people who are best considered as 'healthy'" (2007:1136). Marsland and Hickey (2003) found that nurse training tended to put individuals off, rather than encourage them to work with elderly patients and the students in Melia's (1987) study preferred working on surgical wards (where they felt they were "doing things for the patient" to "just passing time" on a geriatric ward (1987:39). "Typically" writes Melia, "it was the lack of reward or results and the tedium which caused the students to dislike geriatric nursing or at least, to dismiss it as not really nursing." (1987:140).

Choosing to work in hospice or palliative care nursing

While English nursing students qualifying in the early twenty first century have often had the opportunity to experience this area of work while in training, this was not previously the case, and this perhaps explains the lack of information on how hospice or palliative care nursing ranks in attractiveness for students approaching the end of their nurse training.

Given the frequent finding that nurses find it rewarding when their patients recover and go home, one might reasonably ask what might lead nurses to choose to care for patients for whom there is no hope of recovery. The fact that hospice nursing is a relatively unusual choice is poignantly illustrated by Lush (1991:32). In her history of Trinity Hospice in London, Lush quotes a nurse working at the hospice, who wrote "By admitting openly that I have seen death and chose of my own free will to work in its proximity can be quite a shock to some people." Samarel (1991:62)

observes "Most people, when learning that a nurse works with the dying, assume that it is a depressing, emotionally draining and most unpleasant task." An article by Webster and Kristjanson discussing a qualitative study of the experiences of long-term palliative care workers is entitled "But isn't it depressing?" which, the authors state, is "[a] common question about palliative care from those unfamiliar with the work..." (2002a:15).

As several authors have pointed out (Dobratz 1990; Fisher 1996; Samarel 1991; Mason 2002) working with people who are terminally ill means that nurses are exposed on a day-to-day basis to dying, death and bereavement in a society where death is shunned. Given that working with dying people is often perceived by nurses as a stressful occupation, Copp (1997:4) observes "it is not surprising that a few studies have attempted to identify the motivations and coping strategies of nurses who pursue this work". Ellis (1997:197) observes "It is difficult to conceptualise why palliative care nurses choose to expose themselves on a daily basis to a barrage of emotion, complex family dynamics, pain and death." While she acknowledges that great satisfaction may be obtained from providing pain relief, comfort and support to the dying, Ellis questions "whether this balance of satisfaction outweighs the potential emotional trauma experienced".

There has been relatively little research on the question of why nurses choose to work in palliative care in general or in hospice work specifically (De Vries 2000; Gaydos 2004; Rasmussen et al 1997). In her edited collection of health professionals' discussions of the varied routes through which they came to work in palliative care, Mason (2002) vividly describes how her brother's brain tumour, which eventually led to his death, took her first into nursing and, ultimately, into palliative care. "Little did I know" she writes "that Stephen would be the very special person who, in dominating my life by his absence, not only would influence my ability to care for others, but would also determine my future life in palliative care and offer me the chance to enter into the lives of many others" (2002:67).

Table 3 shows the main studies which have explored this issue.

Table 3: ***Studies of factors in choice of hospice/ palliative care nursing***

Date	Author/s	Country	Description	Sample	Data Collection	Data Analysis
1991	Samarel	USA	Qualitative study of nurses caring for terminally ill and acutely ill patients	10 nurses	Participant observation & interviews	Qualitative analysis using constant comparative method
1995	Rasmussen et al	Sweden	Nurses' reasons, expectations, hopes and concerns about their future work as hospice nurses	19 nurses in Sweden's first purpose-built free-standing hospice	Interviews based on narrative framework	Phenomenological–hermeneutic analysis
1997	Rasmussen et al	Sweden	Study of lived experience of being a hospice nurse	18 nurses as above	Interviews with open-ended questions	Phenomenological – hermeneutic analysis
2000	De Vries	UK (England)	Effect of role-models on palliative care nurses' choice of career	8 hospice nurses	Informal, in-depth, free-style interviews	Qualitative inductive analysis
2002 a & b	Webster & Kristjansen	Australia	Experiences of long-term palliative care workers	6 long-term palliative care workers (including nurse, doctor, volunteer, chaplain, counsellor & allied health worker)	Interviews	Qualitative analysis using Colaizzi's method
2004	Gaydos	USA	Life journeys of hospice nurses	5 hospice nurses	Co-creative aesthetic inquiry / interviews	Qualitative analysis

Following my examination of the reasons why individuals choose to become nurses (see Appendix 2), I found that the literature on the choice of hospice/palliative care suggests five sources of influence: individual/psychological factors, the influence of other people, images of hospice nursing (including experience of this type of work), pragmatic factors and 'accident' or 'chance'.

Individual/psychological factors

Psychological/emotional needs

Vachon (1987:21) reported from a Canadian study that staff working with people who were critically ill, dying or bereaved had a "sense of calling in religious or humanistic terms". A few years later, James and Field (1992:1372) observed that, while English hospices had originally been staffed by individuals seeking to fulfil a "calling", this was no longer the case, and that hospice work was now attracting a different type of staff who "are entering the movement for employment or career

purposes rather than because they were 'called'...". Wright (2002) in an American study, found that some hospice nurses reported "a sense of calling", observing "when asked how they became hospice nurses, the stories were different, but the sense of calling was similar" (2002:214). Gaydos (2004) in a small qualitative American study, concluded that "[H]ospice nursing as a means of transformation and a life pervaded by spirituality distinguished the life journeys of these nurses" (2004:16). Rasmussen et al (1995) in a Swedish study of nurses working in Sweden's first purpose-built hospice, found that relatively inexperienced nurses had applied for the position because they "wanted to give of themselves and/or to grow as a person" (1995:48). Palmer's (1991) small American study found that the four hospice nurses interviewed "expressed a profound need to make an impact on other people's lives, which co-exists with an equally strong need to be self-fulfilled" (1991:35).

Aims and desires

A desire to give good patient care has been found to be a factor in drawing nurses to work in hospice/palliative care by a number of researchers in this field (Taylor et al 1997; Rasmussen et al 1995/1997; De Vries 2000; Dobratz 1990; Rosser and King 2003; Fisher 1996; Samarel 1991). Tremayne (2003) in a study of English nursing students, found that "[a] surprising, almost unique, theme that third year nurses generated, was that dying is often perceived as being synonymous with caring... The students discussed in detail the physical care that they gave to patients, the washing, turning, giving pain relief. By giving physical care a bridge to the giving of psychological care was facilitated. The time they spent with the patient, because they needed more, especially in physical terms, meant that it was validated by other nurses on the ward, they were seen as 'doers'". (2003:17).

In a qualitative study of nurses working in a hospice in Sweden, Rasmussen et al (1995/1997) found that the experienced nurses hoped and expected to enjoy being hospice nurses "provided they [were] able to give good terminal care, that is, nursing care that is experienced as meaningful" (1995:344). The experienced nurses contrasted hospitals (where death was seen as a failure, and where the environment was not conducive to dignified death, families were not involved and patients often died alone) with the hospice, where they expected deaths to be "peaceful and dignified, as one would wish for one's own family" (1995:346). The "good nursing care" which the

nurses hoped to give was seen to involve "patience, respect, integrity and caring according to the family's personal rhythm and wishes" and for good nursing care to occur, time was seen as important: "Good nursing care is about 'time', i.e. nurses feeling that they have time to be available and fully present to dying guests and their families when needed." (1997:332)

De Vries (2000) in an English study of the influence of role models on the choice of hospice work, found that the nurses' moves into hospice and palliative care "was related to a rejection of the hospital model of care and practices that nurses were experiencing while working in the hospital environment, and the difficulty in providing care of the standard they wished to" (2000:85). "The issue that returns again and again in the literature and was articulated by the respondents in this study is that of the detrimental effects of working in the highly stressful, understaffed hospital environment and the loss of job satisfaction that it engendered. The need and desire to provide 'hands-on' nursing and to be 'at the bedside' is, for many nurses, the cornerstone of their reasons for being a nurse. The hospice mode of care and organisation is one of the few environments that offers this opportunity to nurses" (ibid).

Rosser and King (2003) in a small study of the experiences of nurses moving into hospice care, found that all the nurses "expected to provide a high standard of care for patients and their families" and this expectation was partly informed by their disappointment with previous opportunities to give palliative care, and the anticipation of higher nurse: patient ratios." (2003:209)

Studies have drawn attention to the fact that one attraction of hospice nursing appears to be the fact that hospices are able to provide patient-focused holistic care (De Vries 2000; Fisher 1996; Rasmussen et al 1995; Samarel 1991). Fisher (1996) reporting on an English study of the adjustment of members of a professional clinical team to hospice care, observes "The majority of participants highlighted seeing the dying cared for badly in other settings and an interest in holistic care." (1996:319). Samarel (1991) studied nurses caring for terminally ill patients, and found that a strong commitment to the provision of holistic care was a "unifying motivational theme" (1991:81).

Dobratz (1990:120) suggests that hospice nursing may be sought by nurses seeking "less traditional" nursing roles. "In their desire to practice [sic] more 'caring' and more professional

autonomy" she writes, "hospice nursing may be sought by those persons who desire less traditional nursing roles."

A desire for close relationships with patients and to work alongside patients' families have also been found to be factors attracting individuals to work in hospice/palliative care. Palmer (1991) reports that the four hospice nurses interviewed all "said that continuing care for the patient and interpersonal relationships with family members were reasons they chose this career specialization" (1991:35). Rasmussen et al (1995) found that the less experienced nurses in their study emphasised that they expected "personal closeness" to be "the core of their duty" (1995:350) while Webster and Kristjanson (2002b:870) found that respondents spoke of the close relationships they were able to have with patients and "the feelings of personal growth they believed had occurred within the palliative care environment".

Congruence with values/philosophy

Several researchers have suggested that a congruence with individuals' values or philosophy helps to explain the desire of nurses to work in hospice/palliative care. Vachon (1987:194) suggests that "caregivers who work with seriously ill and/or dying persons may well need to have some type of philosophy to underpin the work that they do and to explain the suffering to which they are exposed". Samarel (1991:81) found that the hospice nurses she studied had "consciously chosen to care for the dying, after carefully examining their own beliefs and values related to living, dying and death".

Rasmussen et al (1995/1997) reported that care became "meaningful" for hospice nurses once they were given an opportunity to care for others in accordance with their own values and outlook while Gaydos (2004:17) reported that the life journeys of the hospice nurses in her study were distinguished by "a life pervaded by spirituality".

Personal experience of death

Most studies have found that personal experience of death is cited by some hospice/palliative care nurses as a reason for going into this work (Fisher 1996; Gaydos 2004; McNamara et al 1995;

Rasmussen et al 1995; Vachon 1987; Webster and Kristjanson 2002b). Rasmussen et al (1995:350) found that the less experienced hospice nurses in their study "had previously experienced relatives dying in an undignified way, and of not being part of the care. They themselves had not received the support necessary for moving through the grieving process and had later discovered the value of a compassionate and supportive human being in helping them to get through the death and to let go of the grief". McNamara et al (1995:227) reporting on an Australian study, observed "Many nurses recount a story, relating either to their personal lives or to their nursing experience, that has acted as a catalyst in directing them towards palliative care and hospice nursing."

The influence of other people

Little information is available about the influence of other people on choice of hospice or palliative care nursing. De Vries (2000) in an English study, explored hospice nurses' relationships with childhood role models and related this to their decisions to choose nursing as a career and how this may have influenced them at a later stage to go into palliative care and enabled them to provide care for dying people. Webster and Kristjanson (2002b:868) in an Australian study of health care professionals working in a palliative care service, found that the work of pioneers in palliative care such as Cicely Saunders, Elizabeth Kubler-Ross and Rosalie Shaw had sparked their interest in working in this field.

Perceived quality of patient care

A common theme in previous research has been the drawing of contrasts between the type and level of care provided for dying people in hospitals and that which is possible within the hospice environment (De Vries 2000; Fisher 1996; Palmer 1991; Rasmussen et al 1995; Rosser and King 2003; Webster and Kristjanson 2002b). One of the nurses in Rosser and King's (2003) study of English hospice nurses said "In the ward there was [sic] no facilities to deal with anyone dying, we didn't have the knowledge, and there was no room for relatives, we didn't have any time, we didn't have any counselling skills, we had nothing. And it just felt very inadequate and no satisfaction." (2003:209).

The availability of adequate time to care for patients, openness about death and dying, and working in a multidisciplinary team have all been identified as features of hospice/palliative care which have attracted individuals to work in this area (Rasmussen et al 1995; Fisher 1996; Webster and Kristjanson 2002a).

Moir and Abraham (1996) in a study of final-year students training to be psychiatric nurses, found that they "constructed" distinctive occupational identities by contrasting psychiatric with general nursing. This study was explicitly not concerned with students' 'real' motives for choosing psychiatric nursing "but rather how they manage to construct justificatory accounts for pursuing a career in this field" (1996:296).

Pragmatic factors

Practical reasons for choosing to work in hospice or palliative care such as convenience or a preference for the physical environment hardly feature in previous research. Rasmussen et al (1995) found that some of the Swedish hospice nurses they spoke to had applied because the hospice was "convenient" as they lived close by (1995:351). A few others had applied because they had not had a job at the time the hospice was opened (ibid). We should not conclude that the lack of reference to such pragmatic reasons for choosing hospice care indicates that these factors do not play a role in individuals' choice; this may be due in part to a perception on the part of respondents that these would be seen as 'less acceptable' reasons for choosing hospice or palliative care work.

The need for further research

As this survey of the literature makes clear, research relevant to the proposed inquiry does exist and, in some areas (on, for example, choice of nursing as a career) is fairly substantial. Much of this research, however, comes from countries other than the UK (in particular, the USA, Australia and Canada).

Research in a number of the topic areas covered in this review has relied upon questionnaires, often utilising researcher-devised categorisation and 'closed' questions, which fail to ensure that the questions asked and the responses offered are meaningful and relevant to respondents, and

which fail to provide the 'rich' qualitative data which can aid understanding and which is characteristic of studies adopting a phenomenological perspective.

Some of the relevant areas of inquiry are scantily researched (there is, for example, very little UK work on how qualified nurses choose a specialty in which they will work and none on the influence of nurse training on the choice of palliative care work). While a number of the studies examined here have addressed the question of nurses' 'reasons' for entering palliative care work, none (other than a very small American study by Gaydos (2004) have considered the process of 'becoming' a hospice nurse from the perspective of how nurses 'make sense' of their journeys into hospice work.

At present, we know very little about how individuals come to work as nurses in UK hospices, and nothing about the process by which they come to work in this field. A better understanding of this process would have implications for the recruitment of nurses into this specialty and should help to ensure that steps are taken to maximise their job-satisfaction and hence contribute to an enhancement of the quality of patient care. It would also provide important insights into the way in which nurses make sense of the individual life journeys which have led them to work in hospice settings.

Chapter 3: Mapping the journey: Methodological and philosophical approach

In this chapter I introduce the research strategy I adopted for my study - the route I decided to take in my quest to answer my research questions. I begin by outlining the important links between the research questions we ask and every aspect of the research process, including our methodological/philosophical approach, our choice of research paradigm, the methods we use to gather and analyse data and the nature and status of our research outcomes. I briefly differentiate between 'method' and 'methodology' and explain why a qualitative approach was most appropriate for my own research. I then introduce hermeneutic phenomenology as a particularly useful approach through which to attempt to answer my research questions and outline the implications of my choice for the research process. Finally, I discuss issues of research rigour.

What are the implications of choice of methodological and philosophical approach?

It is clear that there is an absolutely critical relationship between one's methodological/philosophical framework and all aspects of the research process (Fleming et al 2003; Marshall and Rossman 1999; Sanders 2003; Walters 1995). Our philosophical approach has important implications for the way in which we formulate our research questions, the decisions we make on what data would adequately answer our questions, how we go about gathering data and how we analyse that data. Koch (1995:827) in a paper on the use of phenomenological approaches in nursing research, observes: "The philosophical assumptions that underlie a method, and whether those assumptions are consistent with the researcher's own view, seems to me to be the necessary starting point of enquiry." Morse (1998:62) argues that research strategies are "merely tools" and that it is the researcher's responsibility "to understand the variety available and the different purposes of each strategy, to appreciate in advance the ramifications of selecting one method over another, and to become astute in the selection of one method over another."

These comments were helpful to me in thinking about how to approach my research, but it seems to me that there is not a straightforward linear process involved in selecting a methodological approach. Even at the stage of beginning to identify the area I wanted to research, I inevitably had

some idea of what would be an appropriate way to go about answering my research questions, and in a sense I seem to have 'worked backwards' in that my choice of philosophical framework did not 'dictate' how I went about my research. Rather, I had a fairly good idea of how to go about the research but needed a methodological framework to support and give meaning to what I had decided to do and to guide me in doing it.

The aim of my research was to *understand* how individuals understand the process by which they come to work and continue to work as palliative care nurses in English hospices. Since its main aim was to develop understanding rather than to test hypotheses, the study was designed from the beginning to be undertaken using a qualitative, rather than a quantitative approach[1], though my hermeneutic phenomenological perspective developed later in the research process.

Method or methodology?

When I refer to 'methodology' I refer to the general philosophical/theoretical framework I adopted for my research and the assumptions which underpinned that framework (Koch 1999:21). As a general approach to studying a research topic, our methodology establishes how we will go about studying a chosen phenomenon (Silverman 1993:2) while 'methods' are the specific research techniques we adopt to explore our research question (ibid). As Silverman observes, methodologies "cannot be true or false, only more or less useful" (ibid) while the methods we use are also more or less useful "depending on their fit with the theories and methodologies being used, the hypothesis being tested and/or the research topic that is selected" (ibid).

An introduction to phenomenology

Phenomenology was one of several "strong currents in Western philosophy" which were prominent at the outset of the twentieth century alongside, for example, neo-Kantianism, idealism, hermeneutics and positivism (Moran 2000:1). Like other Western philosophical systems, it is concerned with the relationship between "the reality which exists outside our minds (objective reality) and the variety of thoughts and ideas each of us may have about reality (subjectivity)" (Spinelli 1989:28). The term phenomenology is derived from the Greek words *phainomenon* which

[1] For a general discussion of qualitative (or 'interpretive') sociological approaches, see Giddens (1976).

literally means "appearance" - that is, that which shows itself (Spinelli 1989:2) and *logos* ("reason" or "word", hence a "reasoned inquiry which discovers *essences* or appearances ") (Stewart and Mickunas 1974:3).

As a new way of thinking philosophically, phenomenology was first formally announced by Husserl in the Introduction to the Second Volume of the First Edition of his *Logical Investigations* (1900-1) (Moran 2000:1). When he adopted this approach, he "supplied it with new meaning and significance", wanting "nothing less than to develop a science of phenomenology that would clarify how it is that objects are experienced and present themselves to our consciousness" (Spinelli 1989:2). Husserl regarded himself as the founder of a completely new discipline (Moran 2000:2). His quest was of the nature of a scientific mission: the development of "a rigorous science based on philosophy, sound perceptions, ideas, and judgments" (Moustakas 1994:45). For him, phenomenology would be a "science of science" - a rigorous clarification of what essentially belongs to systematic knowledge (Moran 2000:60).

In attempting to define the word phenomenology one must bear in mind the fact that a wide diversity of viewpoints, subject areas and variations of method have contributed to its development. Concluding their guide to phenomenology, Stewart and Mickunas observe "It should now be obvious that phenomenology is not a homogenous and dogmatic philosophy but a way of re-opening the basic philosophic issues that deal with the foundational questions of all human endeavours" (Stewart and Mickunas 1974:140). Phenomenology, they point out, "is not a rigid school or uniform philosophic discipline. There is great diversity in the points of view of thinkers who could be classified under the general rubric 'phenomenology', and the most proper description of this way of approaching philosophy is a phenomenological movement" (Stewart and Mickunas 1974:4).

Phenomenological approaches in general seemed to me to represent interesting and useful avenues which I could explore in developing the philosophical structure on which to base my attempt to develop an understanding of hospice nurses' understanding of their routes into hospice work. Precisely which path I should follow, however, was initially not so clear.

However difficult it may be to express the essence of phenomenology in a few paragraphs, it should be possible to identify some of its basic characteristics. Becker has defined phenomenology as "the study of phenomena of things or events in the everyday world" (adding that phenomenologists "study situations in the everyday world from the viewpoint of the experiencing person" (Becker 1992:7).

From a phenomenological viewpoint, individuals are regarded as subjects rather than objects; there is "[a]n active, experiencing person... at the core of every action" and people are seen as creating or co-creating their lives (Becker 1992:14). Phenomenologists assume that human experience is a valid source of knowledge and that people's everyday experiences contain important insights into phenomena (Becker 1992:34). It has often been argued, notes Moran, "that the main contribution of phenomenology has been the manner in which it has steadfastly protected the subjective view of experience as a necessary part of any full understanding of the nature of knowledge" (Moran 2000:21). Within this approach, the interpretational process must be acknowledged in our statements about reality. "Indeed, phenomenologists suggest that, in our everyday experience of reality, this process is to all intents and purposes indivisible from the reality being perceived. Reality, as far of each of us experiences it, *is* this process" (Spinelli 1989:4).

My understanding of phenomenology as it was originally conceived by Husserl is of a philosophical approach which sought to establish universal truths or 'essences' of everyday phenomena and whose main concern was to examine how individuals come to 'know' what they know. From a phenomenological viewpoint, as I understand it, humans are regarded as active, experiencing subjects who create and co-create their worlds and human experience is seen as a valid source of knowledge. Concerned primarily with how things appear to consciousness and assuming that it is possible to eliminate preconceptions and assumptions in seeking 'essences', phenomenology is committed to description, rather than to explanation.

Phenomenology in sociological and nursing research

Within the discipline of sociology, there is a well-established tradition of phenomenological research, as is evident in the work of a succession of influential theorists (Giddens 1976). Phenomenology has also become widely used by researchers in nursing, with several writers

having drawn attention to the increasing popularity of the approach (Hallett 1995; Beck 1994; Fleming et al 2003; Mitchell 2002; Van der Zalm and Bergum 2000; Dunniece and Slevin 2002; Larkin 1998). "One way to understand the truth of 'knowing' in palliative care" say Dunniece and Slevin (2002:13) "is to map the meaningful experiences and perceptions of nurses. Phenomenology as a method of enquiry into the perceptions of human experience, is appropriate to explore phenomena of interest to the nursing discipline." Larkin, in a paper on the lived experience of Irish palliative care nurses, noted "Hermeneutic phenomenology has been identified as a valuable framework in undertaking nursing research and enables nurses to explore aesthetic knowledge about their practice" (Larkin 1998:120). Beck, in her discussion of nursing students' experiences of caring for dying patients, notes that "phenomenology was the qualitative design chosen to explore an understanding of the essential structure of nursing students' experiences providing care for dying patients" (1994:409). Carroll used a "phenomenological heuristic" approach, offering nurses an opportunity to "tell their stories and to share their experiences of their own personal beliefs, and of providing spiritual care to patients with advanced cancer" (2001:81). She chose a Heideggerian approach partly because "it allows the researcher to incorporate the creative self-process and self-discourses into the research process". Mitchell (2002:3) in her report on a hermeneutic study of students undertaking nurse training, clearly sets out the steps she took to identify an appropriate theoretical perspective for her research, including the specific choice of hermeneutic phenomenology and the adoption of a Heideggerian approach.

Phenomenological approaches have been widely used in research on palliative care nurses and their experiences of their work (Ablett and Jones 2007; Barnard et al 2006; Benzein and Saveman 1998; De Vries 2000; Dunniece and Slevin 2002; Larkin 1998; Rasmussen et al 1995/1997). Of particular relevance for my study was research undertaken by Rasmussen et al (1995/1997) using a phenomenological approach to examine the "reasons, expectations, hopes and concerns" of nurses working in Sweden's first purpose-built, free-standing hospice.

Perspectives within phenomenology

Phenomenology is not a single, unified philosophical approach. Its two founding thinkers, Husserl and Heidegger, adopted widely different perspectives, and when I first began to read the phenomenological literature, I realised that the differences between their approaches was

something I needed to grasp in order to decide which approach came closest to my own understandings and assumptions about the nature of the social world. Husserl was the leading proponent of 'transcendental phenomenology' (see, for example, Husserl 1964/1970) which refers to the fact that his approach "adheres to what can be discovered through reflection on subjects and their objective correlates" (Moustakas 1994:45) - that is, how we know what we know. Husserl's philosophical interest, unlike that of Heidegger and Gadamer (who developed the work Husserl had begun along quite a different path) was always an epistemological one - to him, it was knowledge, rather than being, that was the important issue for philosophy. Husserl sought to establish "the conditions of knowing and the provision of a reliable foundation of knowledge" (Fleming et al 2003: 114). His commitment to transcendental phenomenology came from a search for a science of essences - he believed philosophy should be concerned with 'essence' which he saw as a fact or entity that was universal, eternally unchanging over time and absolute (Walters 1995:792). Phenomenology, he believed, offered a way in which we could look at a phenomenon in which we were interested and identify these 'essences' or basic truths. Ultimately, Husserl hoped that his philosophical method would elevate philosophy to the status of a rigorous science (Walters 1995:792).

Husserl's phenomenology focuses on a description of the lived world that conceptualises people as "detached subjects in a world of objects" (Walters 1995:792) and "retains the Cartesian notion of the objective and subjective". In this view, observes Walters, what is "out there" (objective) is presumed to be independent of us (as subjects) and knowledge is achieved "when a subject correctly mirrors or represents objective reality" (op cit:794). One important correlate of this Cartesian view is Husserl's belief that, to establish the 'truth' of human experience, it was possible and necessary for us to 'bracket' or suspend our assumptions and preconceptions regarding the phenomena in which we were interested. He believed that only experience which was stripped of preconceptions, theories and associations could help us to develop universal truths. Husserl thus believed in a pure suppositionless beginning in philosophy and saw previous understandings as an impediment to knowledge (see, for example, Husserl 1970:263).

Heidegger was a student of Husserl and was strongly influenced by his ideas, although his own version of phenomenology, which he called 'hermeneutical phenomenology', differed very

significantly from Husserl's original ideas. One important way in which he diverged from Husserl was in his acknowledgement that our understanding of the world is not, and cannot be independent of interpretation, and he completely rejected Husserl's insistence that we should set aside our preconceptions. He argues that this is not possible, not sensible and not desirable, because humans are essentially *interpreting* beings and their understanding of the world relies on interpretation.

Although I was initially drawn to Husserl's work, I found myself unable to accept his idea of bracketing assumptions and I have found that a number of other researchers in very closely-related fields have come to the same conclusion (see, for example, Dunniece and Slevin 2002; De Vries 2000; Mitchell 2002; Carroll 2001). More helpful to me was the work of Heidegger and other writers including Gadamer, who argue that the researcher's own experience and pre-conceptions must be accepted as part of any research project (see, for example, Gadamer 1989). Heideggerian phenomenology does not begin from an object-subject conceptualisation of the world, and therefore does not include the notion of being able to bracket our experiences of the world. The implication of this perspective is that researchers and their beliefs will be an important part of the research process (Walters 1995:796).

Gadamer agrees with Heidegger that it is neither possible nor desirable to set aside our preconceptions, but he goes considerably further than Heidegger in arguing that our preconceptions in fact have a very positive role in helping us towards understanding. While researchers in the natural sciences see assumptions and preconceptions as negative and would make significant efforts to 'control' them (Fleming et al 2003:115) for Gadamer, it is only through one's *previous* understandings that understanding is possible. Failure to recognise one's previous understandings, says Gadamer, carries a risk that one will fail in the quest to achieve understanding or will misjudge meaning (Fleming et al 2003, drawing on Gadamer 1990)." The important thing" suggests Gadamer, "is to be aware of one's own bias, so that the text[2] may present itself in all its newness and thus be able to assert its own truth against one's own fore-meanings" (Gadamer 1988:238). "Methodologically conscious understanding" says Gadamer "will

[2] Gadamer refers here to 'text' as the primary subject of interpretation, but his approach would include other forms including conversation and interview material as subjects for interpretation.

be concerned not merely to form anticipatory ideas, but to make them conscious, so as to check them and thus acquire right understanding from the things themselves" (op. cit.:239).

My own decision not to attempt to 'bracket' my preconceptions but to include them as part of my research was one which has been made by other researchers in closely-related fields. Mitchell (2002), who devoted a whole chapter of her report on nurses' experiences of a Project 2000 course to her own role in the research, chose to make her preconceptions clear: she writes " I believe that my background greatly influenced the analysis and therefore should be included in the data. By making my fore-understandings conscious and by examining their origin, I believe that I have engaged in an insightful process of metatheoretical reflection which is considered to be a form of inquiry itself" (Mitchell 2002:24-5).

Whereas Husserl was primarily interested in epistemology and questions concerning knowledge, Heidegger's work comes from an ontological position - his lifetime interest was in the meaning of *being*, which he saw as having suffered complete neglect within philosophy. To him, questions such as 'how do we know what we know?' were less important than questions such as 'what does it mean to be a person?' (Koch 1995:832). Heidegger used the word *Dasein* ('being there') to refer to being which understands its own being - for him *Dasein* is a conscious being and is the kind of consciousness which belongs to human beings. *Dasein*, says Heidegger, is essentially in the world - for him, man cannot be separated from the world around him and his understanding is based on his experience of being-in-the-world (Heidegger 1973). Heidegger uses the term 'thrownness' to indicate that *Dasein* finds itself placed in the world. There are many things it cannot control and has not itself brought into being, including an individual's ethnicity, social class, gender, geographical location and historical period, but *Dasein* does have the power to make choices in the world in which it finds itself 'thrown'. It is this assumption that person and world are inseparable in terms of the individual's *understanding* of the world that enables me to legitimately bring my experiences and understanding to my research and, indeed, indicates that it is not something that can be left out of the research process (Walters 1995:796).

The notions of 'care', 'concern' and 'solicitude' are central concepts in Heidegger's thinking, and for him these represent basic modes of *Dasein* (Heidegger 1973). To him, 'care' is a structure of our

own being and is expressed in all the different ways we relate to the entities in our world (Crotty 1996:84). *Dasein*'s way of being, says Heidegger, is to be with others, and 'solicitude' is expressed in forms such as providing food and clothing and nursing the sick body (Crotty 1996:84). It is, says Heidegger, care (*Sorge*) that signifies a man's existence and makes it meaningful. To be-in-the-world in an authentic[3] existential way is to be 'careful' and care is *Dasein'*s state of being as it strives towards authenticity (Heidegger 1973). 'Caring' has been identified as the essence and unifying domain of nursing (Mitchell 2002:30) so it is perhaps not surprising that this aspect of Heidegger's approach has attracted a number of nurse researchers to his work (Mitchell 2002).

Whereas Husserl would suggest that we can consider phenomena in our world in an objective and uninterpreted way, Heidegger argues that nothing can be encountered without reference to a person's understanding. The framework of interpretation we use is the fore-conceptions we have already developed (Heidegger 1962). For both Heidegger and Gadamer, interpretation was not an isolated activity but was the basic structure of experience, and both held the view that the scope of hermeneutics should not be restricted to the interpretation of texts. In his analysis of *Dasein*, Heidegger extends the remit of hermeneutics beyond the interpretation of the written word to encompass the exploration of being. As Klemm puts it, with the publication of Heidegger's *Being and Time* (1973), "the primary meaning of hermeneutics was disjoined from the problem of the development of principles for textual interpretation and reconstituted as the interpretation of existence" (Klemm 1983:27). Since my research essentially concerned interpretation (my interpretation of nurses' interpretations of their routes into hospice work) the perspective offered by Heidegger and Gadamer held considerable appeal.

Central to the thinking of both Heidegger and Gadamer is the concept of the 'hermeneutic circle' which suggests that every interpretation presupposes some level of existing understanding. In terms of the research process, I found this concept very meaningful. It suggests that the researcher is able, through his/her initial understanding, to understand a participant in a certain way. The understanding of the participants will influence the understanding of the researcher (Fleming et al 2003:118) and over time, through a 'fusion of horizons' (Gadamer 1988:350),

[3] Heidegger uses the terms 'authentic' and ' inauthentic ' to describe the extent to which *Dasein* reveals or conceals itself (Heidegger 1973). In my understanding, he refers here to the extent to which an individual is 'true to themselves' or the extent of 'being' who one is.

understanding will be refined. Both Gadamer and Heidegger saw language as the medium through which social actors come to understand one another - for them, the 'fusion of horizons' which occurs by negotiation between individuals was only possible through shared language (Fleming et al 2003:118).

While Husserl did not take any account of the way in which individuals' histories helped to shape their views of the world, the concepts of 'time' and 'historicity' are core concepts in Heidegger's work (Heidegger 1973) and are inextricably linked with his idea of the hermeneutic circle (Koch 1995:80). The temporality of *Dasein* is brought into focus by the certainty that all Being is a Being-towards-death (Heidegger 1973:296). Gadamer also recognised that philosophy had ignored the effect and power of the past on our current understanding and his *Truth and Method* (1989) is concerned with how individuals make sense of their lives by anticipating the future in the light of the past. This aspect of Heidegger's and Gadamer's work had special relevance for my proposed work with hospice nurses. Koch (1995:829) argues that, in phenomenological research "the recounting of past experience is regarded as reliable data insofar as it is an expression of the feelings, thoughts and emotions involved in the phenomena being described. Data produced from memory and recall are not collected with the intention of generalizing to a larger population but rather to add to, and to enhance, the composite human phenomena with which we understand lived experience."

Choosing a data collection method

Right from the time I first thought of undertaking research with hospice nurses, I had made an assumption that the best route to obtaining understanding would be to use in-depth, semi-structured interviews. This assumption came partly from my previous experience as a researcher which had given me a grounding in both quantitative and qualitative research methodologies. I knew that using a structured questionnaire would not be appropriate for two reasons. My aim was to develop an understanding of how nurses made sense of their journeys into hospice nursing and as I had little idea, at the outset, what factors might be relevant to them, it would have been quite impossible - and totally inappropriate - for me to design a questionnaire which would include all possible aspects of their experience and understanding. I wanted to find out what was important to the nurses *themselves* - to understand how the nurses understood themselves - and it seemed to

me that a much more 'open' technique which would allow them to reflect upon and verbalize their experiences and understandings would be required.

The interview is the most widely used method of producing data in qualitative research (Marshall and Rossman 1999:108). As defined by Green and Thorogood (2004:79) it is, in essence, "a conversation that is directed, more or less, towards the researcher's particular needs for data". As used in the social sciences, interviews vary from completely structured (i.e. with specified questions asked in a specific order and with set responses) to the completely informal 'opportunistic' interview used in some ethnographic studies. Following Kvale (1996:46) and in harmony with the ideas of Heidegger and Gadamer, I regard the research interview as a conversation about the human lifeworld, with the oral discourse transformed into texts to be interpreted.

Kvale (1996:54) observes "The qualitative research interview has a unique potential for obtaining access to and describing the lived everyday world " and Larkin, discussing his choice of semi-structured interviewing in his study of Irish palliative care nurses observes "The hermeneutic perception of open, non-directed and unhindered dialogue (Gadamer 1976), indicated the use of in-depth interviews to [help] the respondents to focus on the process of retelling their stories." (Larkin 1998:122).

Semi-structured interviews occupy a middle position on the spectrum from completely structured to completely unstructured interviews. As Kvale (1996:124) describes them, these interviews have "a sequence of themes to be covered, as well as suggested questions." However, "at the same time there is an openness to changes of sequence and forms of questions in order to follow up the answers given and the stories told by the subjects".

Within the semi-structured interview, the respondent is encouraged to discuss experiences and viewpoints which are meaningful to them (Dunniece and Slevin 2002:19; Marshall and Rossman 1999:108) but where the researcher seeks to deepen her understanding, she can encourage the respondent to focus on meaningful issues by the use of probe questions (Dunniece and Slevin 2002:19). Broad, open questions are used to indicate the general topics in which the interviewer is interested, but within this framework, the respondent is free to talk about what she regards as

relevant. Rasmussen et al (1995) in their study of Swedish hospice nurses, used questions such as "Please, narrate your reasons for applying for the hospice position, and the considerations that guided you" to "encourage narrativization" (Rasmussen 1995:345).

The only drawbacks to the use of semi-structured interviews are the fact that they require a certain measure of skill and experience on the part of the interviewer, and the time-consuming nature of interview transcription (such interviews are usually tape-recorded with the permission of respondents).

Crotty (1996:20) suggests that in "true" phenomenological approaches it should be sufficient to ask a single question of the respondent (the argument presumably being that this serves to minimise the interviewer's influence). While I could see the validity of this viewpoint, I decided that a semi-structured interview would better suit my particular purpose. Having located some previous research relevant to my own topic, I hoped not only to obtain my respondents' unique stories of their journeys into hospice nursing, but also to be able to compare my results with those of other researchers. I therefore decided to adopt a three-part interview format, beginning with standard demographic questions (which I hoped would put my respondents at ease as well as provide me with basic demographic data), moving on to an opportunity for respondents to talk about their experiences in an unguided and unprompted way, and ending with an exploration of issues suggested by previous research using open questions. An interview guide would be devised for the first and third parts of the interview to help me to ensure that I would explore the same issues with each respondent, though the precise wording and the order in which I asked about different topics could vary considerably between respondents, with them actively directing the course of the interview. By taking an active part in the interview (guiding respondents to specific topic areas in the first and third sections) and by encouraging respondents to expand upon issues, I envisaged that I would work together with my respondents in the co-production of interview material (Gadamer 1988:350) in such a way that my understanding could be enhanced, thus following Heidegger's and Gadamer's conceptions of the 'hermeneutic circle'.

Using phenomenology in my research

It seemed to me, as I set out on my journey towards understanding, that the ideas of Heidegger and Gadamer had much guidance to offer me. I took from their work an awareness that I was not an objective observer, and that, far from being a hindrance in my search, taking into account my own previous history, my initial understandings and 'biases' was not only acceptable but an essential step. The Heideggerian position that interpreters participate in the creation of understanding "precisely because the hermeneutic circle cannot be avoided " (Koch 1995:832) legitimised my decision to bring my self into my research. I take from Gadamer the notion of co-creation and co-production of data. What is expressed in conversation, he says (or in interviews, in my case) "is not only mine, or my author's, but common" (Gadamer 1988:350). From Heidegger I take a view of humankind as interpreting, questioning, self-reflexive beings for whom their own existence and being is an issue of concern and an awareness that our individual realities are a product of our experience and conditions such as our country of birth over which we have no control.

My search for understanding would involve an attempt to establish a 'fusion of horizons' with my respondents, and the hermeneutic circle would allow us to move towards understanding by sharing our perceptions. The hermeneutic circle would also allow me to use insights from early interviews to explore emerging issues in subsequent interviews. Using a Heideggerian/Gadamerian perspective enabled me to identify the transcripts of my interviews with the hospice nurses as suitable material for interpretation (moving away from the historical use of the concept of hermeneutics towards the notion of hermeneutics as an everyday activity).

With me as researcher being accorded an active role in the research process, I would be able to bring myself fully into the research into my respondents' interpretations and understandings of how their past had brought them to their current role as hospice nurses. As researcher, I too would be bringing my past experience and understandings to the research, seeking not to judge the 'truth' or 'falsity' of nurses' understandings but simply to bring my own understanding to bear on theirs. Heidegger's and Gadamer's emphasis on the importance of historicity in our understanding therefore made a great deal of sense to me. While some might argue that the nurses' memories would be coloured by their current experience (and that I would therefore not be able to obtain a

clear understanding of their paths into hospice work) I would argue that it is only in the light of cumulative experience over time that we are able to make sense of our present. I suggest that narrative - talking about our experience - is not only integral to identity but also constitutive of it.

My choice of research strategy had many obvious effects on the way I undertook and wrote up my research. To begin with, my initial desire to 'put myself into my research' was highlighted as an essential step by my reading in hermeneutical phenomenology. From an early stage, I recognised that my own 'story' was somehow going to have to be used as a 'baseline' for my research and my own preconceptions made clear. After all, I selected this topic from millions of other possible topics worthy of research, so I must have some level of personal interest in it! Accepting this, I have set out brief details of my own 'causal past' to enable readers to understand where I was 'coming from' when I decided to undertake this research and have also set out as clearly as I could the preconceptions and expectations I brought into my research (see Chapter 1).

I felt it was most important to explain to respondents a little of my own history, so that they could understand my interest in my research topic, and my experience of interviewing the nurses made it clear to me that telling my own story and setting my research firmly in the context of that story encouraged them to share their stories with me in a way which I believe would not have been possible had I presented myself as an 'objective' and essentially uninvolved researcher.

In order to make clear to readers how I arrived at my understanding of the nurses' stories, I felt that it was important to transcribe the interviews verbatim (complete with hesitations and pauses) and reproduce the nurses' exact words in my analysis. Clearly, my process of interpretation meant that I, as researcher, selected parts of the transcripts which best illustrated my construction of the nurses' meanings, but this also demonstrated 'co-production' in action.

One important result of my choice of research methodology was my decision to report on my research in the first person. Explaining her decision to write her account of her research on student nurses' experiences of 'becoming a nurse' in the first person, Mitchell (2002:14-15) argues that reporting in the third person "conveys an implication that the ideas being discussed are neutral and value-free". This cannot, she argues, be the case "in a study which uses Self as the major

instrument in the research". All forms of research involve a certain amount of social interaction, but with interpretive approaches, "researchers invest and divulge much of themselves in their research." Another reason why third person writing is inappropriate in interpretive inquiry, she writes, is 'reflexivity', "which requires the researcher to reflect continuously throughout the research process on their actions, participants' reactions to them and how they are collecting, analysing and interpreting data. It is part of the research, otherwise it might not be possible to evaluate it thoroughly." Finally, in reporting on her study, "trying to put descriptions of the processes and my involvement in them into the traditional third person writing would not only have been awkward but untrue to the philosophical premiss of hermeneutic phenomenology which informs the study" (ibid).

A further result of my choice of research methodology relates to the status of my findings. Walters (1995:795-6) observes that, for Heidegger, final interpretations can "only be considered tentative, rather than absolute or true". This being the case, Walters suggests that it is important for researchers working within a Heideggerian paradigm to provide enough information about the research process to enable readers to make their own interpretations (by, for example, providing excerpts of participants' narratives to illustrate the interpretation) (ibid).

Rigour of the research

"All research" observe Marshall and Rossman (1991:191) "must respond to canons of quality-criteria against which the trustworthiness of the project can be evaluated", and within the social sciences generally, the concept of "research rigour" has "traditionally encompassed concepts of validity and reliability" which relate to both the methods and findings of the research (Ersser 1997:104).

'Validity', which in quantitative research has a "set of technical microdefinitions"" (Janesick 1998:50) has been broadly defined by Hammersley (1990:57) as "the extent to which an account accurately represents the social phenomena to which it refers" while 'reliability' refers to the consistency, stability and repeatability of research results (Hollway and Jefferson 2000:79).

The types of concerns which flow from the search for validity and reliability include the extent to which researchers have introduced 'bias' into their research, how researchers themselves have affected the results they obtain and how repeatable and generalisable the research is. Walters (1995:795) observes that the traditional notion of research validity "originated in the physical sciences, and is based on the notion of objective truth." Kvale (1996:239) also notes that a belief in an "objective world" has been "the basis of a modernist understanding of truth and validity." In a positivist philosophy, says Kvale, "knowledge became a reflection of reality: There is only one correct view of this independent external world, and there is ideally a one-to-one correspondence between elements in the real world and our knowledge of this world" (ibid). The implication here is that the researcher can "stand back" from what is studied and view it "objectively, in a value-free and neutral way" (Stanley and Wise 1993:117).

I align myself with the interpretivists in arguing that it is neither possible nor sensible for social researchers to assume an objective truth which can be identified by the use of 'rigorous' research. Heideggerian phenomenology, unlike that of Husserl, does not accept the notion of "letting the facts speak for themselves" or of knowledge independent of interpretation. It "transcends the notion of analysing human experiences in positivistic terms and, therefore, does not accept the view of validity as defined by the positivistic sciences" (Walters 1995:795).

Marshall and Rossman (1999:28) argue that the qualitative researcher's challenge is "to demonstrate that [their] personal interest will not bias the study." While accepting that researchers need to be very *aware* of and make manifest their preconceptions of and attitudes towards their subject of study, however, I would argue, with Heidegger and Gadamer, that the researcher's 'biases' or 'prejudices' are essential starting points for any piece of research which aims to enhance understanding.

If we accept Ellis's point of view that, in interpretive social science, there is "no single standard of truth" (2004:361) and hence no objective measure of the "rightness" or "wrongness" of a researcher's interpretation of her data, then the traditional notion of validity cannot be applied (Walters 1995:796).

Generalisation to a wider population (for example, the population of English hospice nurses) was never an aim of my research. This is a feature of phenomenological research in general - it seeks to further understanding of a phenomenon, rather than to extrapolate findings to wider populations (Harrison and Burnard 1993:50).

Qualitative studies cannot, by their nature, be replicated precisely (Marshall and Rossman 1999:195), the results obtained from each study being the outcome of a unique interaction between researcher, respondents, time, situation and methods used. Thus the traditional concept of 'reliability' is not an appropriate measure in phenomenological research.

The lack of 'fit' between traditional concepts of validity and reliability and interpretive research methods may, suggest Harrison and Burnard, lead researchers working within this approach to simply set these measures of research rigour to one side as "irrelevant" (Harrison and Burnard 1993:57). I agree with Silverman, however, that while traditional notions of validity and reliability may not offer appropriate measures for the evaluation of interpretive research, researchers nevertheless have a duty to those who will read and draw on their research to provide them with information which will enable them to judge the rigour of their work (Silverman 1993:153). I suggest that those undertaking research within a phenomenological framework would do well to utilise three measures of the rigour of their research: credibility, transparency and utility, and that 'trustworthiness' rather than 'truth' should be our aim.

In seeking credibility, I seek to convince those reading my work of the 'authenticity' of my conclusions (Guba and Lincoln 1981) and give them confidence that these conclusions are 'reasonable' and 'meaningful' in the light of my research methods and the data on which I base them. Riessman (1993:65) suggests that a researcher's interpretation needs to be "reasonable and convincing" and that the use of evidence from respondents' accounts can help to achieve this (see also Fleming et al 2003:119).

My second criterion of research rigour, 'transparency', is related to the notion of 'auditability' which has been used to describe "the ability of another investigator to follow the decision or audit trail" of a research project (Beck 1997:410). In attempting to achieve 'transparency', my aim was to set out

clearly my decisions, actions and methods for every step of the research process, from initial conception to the formation of conclusions.

By 'utility' I mean the extent to which the findings of the study are useful to other people, whether these be health care professionals, sociologists, members of the public or individuals interested in undertaking similar research. While interpretive research studies may not be generalisable to large populations, observes Ellis, we can judge the value of a piece of research by asking "Does it speak to readers about their experience or about the lives of others they know or unfamiliar lives?" (Ellis 2004:361). Van der Zalm and Bergum (2000:213) suggest that phenomenological description should "reverberate with the reader, making us suddenly 'see' something that enriches our understanding of everyday life experiences." As they see it, knowledge resulting from phenomenological inquiry has the potential to become "practically relevant in its possibilities of changing the manner in which a professional communicates with and acts towards another individual in the very next situation he/she may encounter. Phenomenological knowledge reforms understanding, does something to us, it affects us, and leads to more thoughtful action."

Riessman (1993:68) and Marshall and Rossman (1999:193) suggest that researchers should be able to argue that their research is useful to others who have similar research questions or questions of practice, though Marshall and Rossman (ibid) argue that the burden of demonstrating the applicability of one set of findings to another context rests "more with the researcher who would make that transfer than with the original researcher." I am not thinking here of generalisability of results to wider populations, but of the utility of research *designs* to other researchers.

Seeking to enhance credibility, transparency and utility, I suggest, are useful ways of establishing the 'trustworthiness' of phenomenological studies, and allow us to apply measures of quality while avoiding the assumptions of objective 'truth' implicit in the more traditional measures of validity and reliability.

Fleming et al (2003:119) suggest that researchers adopting a Gadamerian approach have a responsibility to "provide sufficient detail of the processes, as well as the findings in the research report". I sought to do this and to enhance the trustworthiness of my study by:

- Outlining and explaining the preconceptions and understandings which started me out on my research journey

- Providing detailed information on and explanations for my research methodology and its philosophical basis and my sampling method

- Tape-recording and transcribing verbatim all interviews

- Seeking to achieve 'immersion' in my data by repeated readings of the verbatim transcripts

- Making extensive use of respondents' own words in my report on the research

- Providing detailed information on my methods of data analysis

- Asking respondents to complete a checklist as a way of corroborating/checking my interpretation of my interview material.

In the next chapter I discuss the ways in which I built upon my chosen methodological/philosophical framework by undertaking research which I hoped would enable me to answer my research questions.

Chapter 4: The research process

In his book on interviewing, Kvale (1996:4) describes the interviewer as "a traveler on a journey that leads to a tale to be told upon returning home." The interviewer-traveler "wanders through the landscape and enters into conversations with the people encountered" and "explores the many domains of the country, as unknown territory or with maps, roaming freely around the territory". The interviewer "wanders along with the local inhabitants, asks questions that lead the subjects to tell their own stories of their lived world, and converses with them in the original Latin meaning of *conversation* as 'wandering together with.'" (ibid) The journey, says Kvale, "may not only lead to new knowledge: the traveler might change as well."

In this chapter, I describe how, having acquired some methodological/philosophical maps to guide me, I set out on my journey of discovery. Gaining access to the land I hoped to travel was not straightforward, so I describe the various entry-points I had to navigate in order to undertake my research. I discuss the ethical issues I had to consider and the preparation it was necessary for me to undertake in order to talk to my informants. I describe what happened when I finally got to meet the people I had been wanting to meet for so long, and how I attempted to understand the stories they told me and merge them into a meaningful picture which would help to answer my research questions.

Getting permission to do the research: University committees and NHS Research Ethics Committee

Before I could begin to think about making contact with the hospice nurses with whom I wanted to talk, it was necessary for me to obtain permission from two separate authorities. The first of these was the Roehampton University Research Degrees Board and Ethics Committee, which needed to be satisfied both with the academic potential of my research proposal and with its ethical acceptability. My original research proposal underwent a process of expansion, refocusing and refinement, and at the request of the University authorities, several sections of the proposal had to be rewritten to provide fuller and clearer information. My second submission of the proposal to the Research Degrees Board and Ethics Committee was successful, with the application receiving

approval on 7 November 2005 (Ethics Committee) and 10 November 2005 (Research Degrees Board).

Any research conducted on NHS premises has to receive approval from a NHS Research Ethics Committee. Since most hospices in the UK receive part of their funding from the NHS, I was informed that I would be obliged to obtain Ethics Committee approval before approaching hospices to recruit respondents. The primary purpose of these committees is to protect the interests of patients, but research of any nature must receive approval, and application involves on-line completion of a lengthy application form which sets out the ethical implications and provides full details of the proposed research.

I had been advised that getting NHS Ethics Committee approval could be a time-consuming exercise, and this proved to be the case. The first committee I contacted had a backlog of applications and suggested I apply to another local committee. My application was considered at a meeting of this committee on 19 October 2005 and a small number of minor amendments and elucidations was requested. Approval would be conditional upon interviews being conducted in the workplace during working hours (unless participants specifically preferred to be seen in my home), interviews were to be limited to one hour if possible and no more than thirty respondents were to be interviewed. I was required to confirm that I would send a summary of results to each respondent and a maximum of three research sites were to be used unless recruitment numbers were too low (in which case a fourth hospice could be approached).

My intention had always been to offer respondents an interview on work premises if possible, but the requirement that interviews be strictly time-limited and undertaken during working hours had clear implications for both recruitment to my study and the quality and quantity of material I could expect to obtain. The fact that interviews were to be undertaken in working hours might, I felt, make it more difficult for me to persuade senior nurses to release staff, although it might also make nurses more willing to be involved as they would not have to give up an hour of their own time. The requirement to undertake the interviews on hospice premises would mean that I would have to obtain the use of a quiet room where I could talk to respondents undisturbed and in total privacy. Limiting the interviews to one hour would have benefits in terms of transcribing my tape-recorded

interviews, but it might limit the 'completeness' of personal stories I was able to obtain. In the event, all interviews except one (which was longer) took between one and one and a half hours.

Since I could not proceed without obtaining NHS Ethics Committee approval, I complied with the restrictions imposed and on 2 November 2005, received final approval to undertake my research.

Respondent numbers and criteria

My approach to selecting hospice nurses to interview for my study was guided by the aims of my study. Rather than attempting to obtain a sample of nurses who were fully 'representative' of the population of English hospice nurses in order to be able to generalise to this population, my aim was to produce rich, thick descriptions of experience which would provide me with an understanding of what 'becoming and being a hospice nurse' meant for them. Kalideen (1994:17) notes that the prescriptive rules of sampling which apply to quantitative studies, and which have a direct bearing on reliability, validity and generalisability of the findings, are not appropriate in qualitative studies, which require appropriate samples of informants who are best able to meet the information needs of the study (see also Ersser 1997:288; Barnard et al 2006:7; Kvale 1996:102).

Purposive sampling is a non-probability sampling method which allows the researcher to select interviewees whose qualities and/or experience permit an understanding of the phenomenon in question. Previous studies which have used purposive samples include Yang and Mcilfatrick's (2001) study of intensive care nurses' experiences of caring for dying patients, De Vries's (2000) study of the effect of role models in encouraging nurses to work in palliative care, Rosser and King's (2003) study of nurses moving into hospice work, Sanders' (2003) study of nurses' spirituality, Barnard et al's (2006) investigation of how Australian nurses understand the experience of being a palliative care nurse and Dunniece and Slevin's (2002) study of the less articulated knowledge used in practice by palliative care nurses.

Because the emphasis is on depth and quality of data, the sample sizes of qualitative studies tend to be much smaller than those used in quantitative research. Kvale (1996:101) observes that, in a qualitative study, we simply need to "[i]nterview as many subjects as necessary to find out what

[we] need to know". Respondent numbers in interview studies undertaken around the time Kvale was writing tended to vary between five and 25 (Kvale 1996:102).

For my own study I adopted a purposive approach to sampling. My aim was to recruit 30 qualified nurses working in English hospices. Bearing in mind the staffing implications for hospices which might not employ large numbers of nurses and my own mobility restrictions, I decided to approach three hospices within reasonable travelling distance of my home, with a view to recruiting around ten nurses from each. For basic demographic information on respondents, see Appendix 3.

Gaining access to the hospices

Since I was a total 'outsider' with no contact - formal or informal - with the staff at the hospices I decided to approach, my initial communication was likely to be very important in either opening gates or ensuring that they remained firmly closed. Not only was I not known to the nurses at the three hospices; unlike De Vries (2000) and Ersser (1997) I was not a nurse but a medical sociologist and would therefore be even more of an 'outsider' than I might otherwise have been.

My initial contact with the three hospices in southern England took the form of a letter addressed to the medical director or other most senior individual listed in the *Hospice and Palliative Care Directory* (Brasch 2005). The letter provided a brief outline of my proposed research, confirmed that the proposal had been approved by the local NHS Ethics Committee, and asked if I could meet with them with a view to discussing the possibility of my interviewing some of their nurses.

Two of the three senior staff I contacted by letter replied, inviting me to discuss my project with them. At the third hospice (to which I refer as Hospice 2 because it was the second at which I undertook interviews) my initial contact left before we could meet to discuss my research. I eventually established contact with a second individual, but after much chasing-up of e-mails, I finally learned that this person too, had left the hospice. Had it not been for an extremely helpful junior doctor, who recognised from the correspondence trail that I had experienced considerable problems with communication and suggested we meet to discuss my research, I might have been tempted to give up on Hospice 2 and look elsewhere. As it was, approval was received (informally)

at that meeting and I went on to meet with a senior nurse who would act as my gatekeeper at Hospice 2 and made short, informal presentations to two groups of potential respondents at this hospice.

Negotiating access at Hospice 1 was comparatively straightforward. Here, I met with a senior member of staff soon after sending my letter of inquiry and received immediate agreement (although this was subject to the completion and approval of a short application form to be considered at the hospice's own ethical committee). I was put in touch with a senior nurse who would act as my gatekeeper at Hospice 1, and this individual was most helpful in suggesting the names of nurses who would be willing to talk to me.

After a protracted process of discussion, the third hospice from which I had initially hoped to recruit participants declined to participate in my study. Fortunately, however, in February 2007, I made contact with a senior staff member of a fourth hospice (to which I refer as Hospice 3) through the recommendation of one of my participants at Hospice 2. By recruiting nurses from this hospice (where approval was given quickly and relatively informally) I was able to complete my sample of 30 qualified hospice nurses.[4]

Maintaining regular and friendly contact with my gatekeeper nurses at the three hospices helped me to ensure that my project continued to claim their attention against competing demands on their time. An information sheet (see Appendix 4) was given to nurses who said they would be willing to be interviewed and to all those attending the two presentations at Hospice 2.

Several writers have drawn attention to the importance of the way in which researchers present themselves to those from whom they seek information. Ersser, who undertook doctoral research on nursing as a therapeutic activity, found that stating his identity as a qualified nurse was of "great significance in terms of patients' willingness to disclose to me throughout the study" (1997:98). Melia, who studied student nurses, was careful not to be seen as "in any way connected with their college or hospital 'establishment'" in order to foster trust (Melia 1987:194) and found that stating

[4] This included three nurses currently working for hospice community teams, all of whom had substantial experience of working on hospice wards.

her own research student status often created a feeling of comradeship in the "we are all students together" sense (1987:194).

As part of my MSc course in Medical Sociology, I undertook a two-week placement at a geriatric hospital, which had been arranged at the last minute by a consultant geriatrician when my first choice of placement fell through. I was introduced to the ward sister on the ward to which I was allocated simply as " a student " who wanted to undertake observation in a health care setting. It was not until close to the end of my observation period that a friendly student nurse told me in confidence over lunch that the whole ward routine had been changed because I was suspected of being "a time and motion person". I also learned that a number of potentially revealing 'scenes' involving confrontations between student nurses and the ward sister had been carefully covered up. This experience had taught me the importance of being explicit and clear about who I was and what I was hoping to achieve. In my initial letters to senior hospice staff, in the information sheet I gave to nurses prior to interview, and also when introducing myself to nurses at the beginning of interviews, I referred to myself as "a medical sociologist undertaking doctoral research". In addition to this statement of identity, I always added a reference to my very personal interest in my subject of study, referring to my personal losses and with special reference to the death of my husband in a hospice which had started me on my journey of discovery. While it was clear that telling the nurses about my own experiences of death was very helpful in 'breaking the ice' and establishing common ground, my identity as a 'research student' (= 'academic'/'outsider') may have put off some nurses and encouraged others - perhaps those who were more articulate or had thought more about their own reasons for going into hospice work - to talk to me. One nurse at Hospice 3, whom I encountered twice while waiting for meetings with interviewees, was adamant that I would get nothing out of talking to her and that she could tell me all she had to say on my topic of study "in five minutes". She, of course, was one nurse I would very much have liked to have included in my study, but my rules of engagement were such that I did not get a chance to challenge her belief that she had nothing to say!

Whether one is an 'insider' or an 'outsider' is likely to have an effect not only on respondents' willingness to be interviewed but also on what they feel 'safe' to confide in an interview. De Vries, who was working as a hospice nurse in the institution in which she undertook interviews, had an

advantage in so far as it was not necessary for her to establish rapport with her respondents "as all respondents were known to me" (2000:37). As Reinharz (1992:26) observes, being known to respondents may increase credibility, while the specialist knowledge of 'insider' interviewers may enhance the quality of interview data. On the other hand, says Reinharz, in some studies the fact that the researcher is *not* known to respondents can encourage them to provide detailed personal information (she cites a study of abortion) (ibid). I took it as a measure of their trust in my independence and integrity that a small number of my own respondents openly criticised other members of hospice staff (in some cases, members of staff whom I also interviewed). One respondent - the only one who requested that the interview be undertaken in her own home - was so open in discussing her life and experience that she contacted me very shortly afterwards in a state of some anxiety and insisted that I should not publish any personal information which might make her identifiable. I had, in fact, made it very clear in the information I gave respondents that all information would be regarded as strictly confidential and that no real names or identifying information would be published, but on this occasion I re-emphasised this guarantee of anonymity.

Ethical considerations

Punch (1994:92) notes that "Conventional practice and ethical codes espouse the view that various safeguards should protect the privacy and identity of research subjects." In quantitative research studies, confidentiality is assured by "computed averages in survey responses" (Kvale 1996:154) but qualitative studies which involve a small number of respondents who provide intimate personal information and who may be drawn from a relatively small population require very careful attention to the protection of respondent confidentiality (see, for example, Ellis 2004:174-5).

Kvale (1996:115) draws attention to the conflict between the "ethical demand for confidentiality" and the "basic principles of scientific research, such as inter-subjective control and the possibility of reproducing the findings by other scientists." In qualitative research, we would not expect two interviewers asking the same research question to produce identical interview data from any one subject, but the balance between protecting the subjects of study on the one hand and ensuring rigorous research on the other (Sheridan 2009) is one which many qualitative researchers have to attempt to achieve. One way in which researchers can address this problem is to omit or change

more specific data, "guaranteeing confidentiality at the expense of some of the data's richness" (Andrews et al 2008:51).

In undertaking my research, I had a responsibility to ensure that everything my respondents told me was treated as completely confidential, that their anonymity and privacy was assured and that they were not harmed in any way. In line with my undertaking to ensure safe storage of interview material, audio tapes of the interviews were kept in a locked filing cabinet and marked only with the respondents' study number. Each respondent was assigned a pseudonym, which was used on typed interview transcripts, and the list linking respondents' actual names with the pseudonyms was kept in a separate locked filing cabinet. Information about the storage of interview material was provided on both the consent form respondents signed at interview and the information sheet provided beforehand (Appendices 4 and 5).

Marvin (2006:199) questions the extent to which the people studied by anthropologists "always, and fully understand exactly what it means or might mean to have articles and books written about them or to have their lives, beliefs, opinions, and actions, discussed in books, articles, conferences or lecture rooms." As a researcher, I had a duty to ensure the protection of my respondents' privacy and therefore made it clear that no identifying details would be included in any publication resulting from my research (see Appendix 4). To fulfil this requirement it was necessary for me to make a small number of changes in personal information to ensure that individuals could not be identified but, in general, the process of fragmentation which is a necessary part of the process of data analysis should help to ensure anonymity.

Andrews et al (2008:51) observe that research reports which reproduce "larger amounts of data" make it harder to guarantee anonymity "especially when researching an understudied topic with a small community of potential respondents". In my own presentation of interview material (using sometimes lengthy quotations) I could not rule out the possibility that individual linguistic habits might make some respondents identifiable to those who knew them well (Davies 1999:51) but I hoped that the fact that I had drawn my respondents from three different hospices and did not identify individuals with any specific institution would help to preserve anonymity.

Apart from the one conducted (at the respondent's request) in a respondent's own home, all interviews were undertaken in a hospice room out of earshot of passers-by.

Informed consent

Informed consent, says Kvale (1996:112) "entails informing the research subjects about the overall purpose of the investigation and the main features of the design as well as of any possible risks and benefits from participating in the research project". Informed consent, he continues, "involves obtaining the voluntary participation of the subject, with his or her right to withdraw from the study at any time, thus counteracting potential undue influence and coercion".

Information on the purpose of the study, the interviewing process and possible advantages and disadvantages of taking part was included on the participant information sheet given to potential respondents, along with assurances of confidentiality and freedom to decline to take part or to withdraw from the study at any stage (see Appendix 4). Each interviewee was asked to read and sign a consent form at the beginning of their interview (which I countersigned and of which they were given a copy to keep) (see Appendix 5).

The British Sociological Association's *Statement of Ethical Practice* places on sociologists "a responsibility to ensure that the physical and psychological well-being of research participants is not unduly affected by [their] research" (BSA 2002: Para 13). While it was unlikely that my respondents' physical well-being would be threatened by my research, the nature of my inquiry did carry with it the possibility of psychological or emotional harm. I attempted to minimise the potential for "embarrassment as a consequence of research" (Punch 1994:92) by doing all I could to avoid individual nurses being identifiable in my writing-up of the research. There was, however, another possible 'harm' which could arise from my particular research inquiry. Ellis (2004:174-5) refers to the painful memories which may be aroused in talking to respondents about events in the past and I felt that this was especially likely to be a problem in talking about death. It was incumbent on me to ensure that, should one of my respondents become very emotionally distressed in an interview, I would be able to take the necessary steps to help them. Clearly, in such an event, I would switch off the tape recorder and offer to end the interview, but in all

likelihood that would not be enough to prevent harm. This issue was first raised in one of my discussions with senior hospice staff (in subsequent discussions I raised it myself) and since I was not a trained counsellor, the best solution I could find was to ensure that a senior member of the nursing staff would be available to talk to any respondent who became distressed. This availability (agreed with all the participating hospices) was referred to in the information sheet provided to potential interviewees (see Appendix 4). In the event, one nurse did become tearful while recalling the death of a patient to whom she had become emotionally close. In this case I switched off the tape-recorder but she declined my offer to stop the interview and was happy to continue.

Developing the interview guide

My aims were to encourage my respondents to talk as freely as possible, but also to obtain information which would help me to compare my results with those of previous research. Given these aims, I decided to develop an 'interview guide' similar to that used by De Vries (2000) in her interviews with hospice nurses on the effects of role models in encouraging nurses to work in palliative care. Using this approach, De Vries was able to "establish a conversational style and to word questions spontaneously but maintain the focus within the subject area" (2000:36). Webster and Kristjanson in an Australian study of the experiences of long-term palliative care workers, also used an interview guide approach with "broad questions" "attempting to capture the meaning of palliative care as experienced by the participant" (2002b:866).

My interview guide was divided into three parts. At the beginning, I planned to have a brief, informal introduction in which I would explain briefly why I was interested in finding out about nurses' paths into hospice work. Part 1 was designed to provide me with basic personal and demographic information and to put respondents at their ease. In Part 2, having checked whether my respondents had ever 'told their story' before, I would ask them to "tell me a bit about what led you to be interested in nursing and how you came to be working in palliative care". In the final part of the interview, I would pick up on issues raised in previous research, ask about future work plans and explore perceptions of the ways in which hospice/palliative care differed from other specialties (see Appendix 6). At the end of each interview I would give respondents a checklist to complete, thank them for their help and explain that a copy of the interview transcript would be sent to them

for feedback. My plan was to cover as many of the topics in Part 3 as possible, but not necessarily to ask questions of each respondent in the same way or to raise topics in the same order.

Putting together the interview guide was a process which I undertook over a considerable length of time. From the time I commenced the research (April 2004) and guided by my specific interests and reading, I collected ideas for suitable questions and themes, while bearing in mind that my intention was to conduct relatively unstructured interviews to allow respondents to "tell their own story" in whatever way they chose. Awareness that a completely open format might jeopardise my chances of exploring ideas thrown up by previous research led to the development of the three-part interview guide.

Developing the checklist

My decision to ask respondents to complete a short checklist of items including factors suggested by previous studies as influencing individuals' decisions to work in hospice or palliative care was taken with a view to providing evidence which I could use alongside my qualitative data as a form of 'triangulation' (Marshall and Rossman 1999:196). The final checklist, which required respondents to rate the effects of 26 factors on their decisions to become nurses and on their decisions to become hospice nurses was given to respondents at the end of the interview, and where there was insufficient time for completion, I provided a stamped addressed envelope for respondents to return them to me. (See Appendix 7).

Tape-recording and transcribing interviews

Tape-recording of interviews is standard practice within qualitative research (Davies 1999:114; Kvale 1996:160; Marshall and Rossman 1999:148) and is essential if the aim is to reproduce interview material in verbatim form. Using a tape recorder allowed me to focus fully on the flow of interviews and engage more actively in discussion with my respondents and also avoided problems associated with omission and selective recall which might have arisen had I attempted to take notes. Recording interviews is not necessarily a hazard-free enterprise: Kvale (1996:162) observes that many interviewers have painful memories of an interview in which a tape recorder

failed to work. After my thirteenth interview, I was shocked to find that a large part of it had not been recorded and concluded that this was attributable to my use (unique to that interview) of rechargeable recorder batteries. Very fortunately, the respondent concerned was willing and able to arrange another interview with me, but in all subsequent interviews I took the precaution of using two tape-recorders!

Discussing hermeneutic research in nursing, Fleming et al argue that conversations with participants should be transcribed verbatim "to capture the historical moment and provide a text with which to engage in dialogue" (Fleming et al 2003:118). While hesitations, repetitions, restarts, pauses and silences do not necessarily make "good quotes" they may nevertheless provide "very important guides as to what people are really striving to say" (Davies 1999:114) and for this reason I decided to transcribe each interview verbatim.

Several writers observe that transcribing interviews verbatim can be extremely time-consuming (Harrison and Burnard 1993:53; Kvale 1996:93; Mishler 1986:50; Riessman 1993:58). Typing up my own interviews *was* very time-consuming, but it did have the advantage of immersing me in my data in a way which would not have occurred had I handed the job over to someone else to do. As I took the view that *everything* respondents said (including hesitations, pauses, repetitions and false starts) was important and that it was also important to record my own exact words, each interview took me at least six hours to transcribe. An entry in my Research Journal for 5 July 2007 reads:

"The interviews are done, the transcripts typed (a monster of a job, but at least I got to know the data better than I'd have done had I got someone else to do it!) And now I have around 750 pages of transcripts to analyse."

Pilot interviews

Before embarking on my interviews, I decided to undertake a small pilot study. This would help me to see how my draft interview guide worked in practice and would also give me a chance to revive and improve my interviewing skills. Because I did not have easy access to nurses working in

hospices (one of the negative factors associated with being an 'outsider') and because of the explicit restrictions on the number of nurses I could interview imposed by the NHS Ethics Committee, I felt I could not afford to use individuals who met my criteria for participation in the project in my pilot study. I therefore made informal contact with a small number of individuals not working at any of the three hospices but working as community palliative care nurses, in related specialties or in professions allied to medicine. Pilot interviews were undertaken with:

- Community palliative care nurse (face-to-face)
- Community palliative care nurse (telephone)
- Senior oncology nurse (telephone)
- Senior neonatal nurse (telephone)
- Speech therapist (face-to-face).

These interviews were extremely helpful in terms of testing the wording of questions (specificity, understandability, non-directiveness), checking for missing topic areas and allowing me to practise my interviewing skills. The interviews also served to re-awaken my enthusiasm for my research topic. One particular interview (with a senior community palliative care nurse) was particularly inspiring and provided many useful insights. Having completed these interviews (some of which I transcribed verbatim) I made necessary adjustments to the interview guide with a view to commencing the full research interviews in July 2006.

Notes on a journey

In a real sense, my data analysis began long before I completed the interviewing phase and turned my full attention to 'analysing my data'. Numerous writers refer to the widespread practice by researchers of keeping field notes, a research journal or other form of recording personal observations as research proceeds (Davies 1999:7; De Vries 2007:7; Reinharz 1983:175; Sanders

2003:295; Webster and Kristjanson 2002b:868). My own 'Research Journal' began in the very early days of my study (March 2003) when I was seeking an academic institution in which to base myself. I added to this journal (written on A4 sheets) regularly as the fieldwork proceeded, noting observations on individual interviews, recording hunches and possible links between issues raised by my respondents and issues I hoped to explore in later interviews. I also jotted down on separate A4 sheets ideas on connections between ideas suggested by my reading and comments made during interviews and later went on to sketch out tentative flow-chart diagrams to aid me in my analysis.

Doing the interviews

I commenced my 'fieldwork proper' in July 2006, beginning with Hospices 1 and 2 and later moving on to Hospice 3 to undertake the final interviews. All but one interview were undertaken on hospice premises, my gatekeeper nurses booking rooms for me. In most cases, interviews were completed without interruptions or disturbance. On one occasion, I interviewed a senior nurse who was having to work 'hands-on' at the same time as supervising staff because of unexpected staff absence, and the interview was interrupted several times by junior members of staff. On another occasion, my discussion with a respondent was disturbed by the noise of structural work being undertaken in a nearby room.

Marshall and Rossman (1999:113) observe that "The primary advantage of phenomenological interviewing is that it permits an explicit focus on the researcher's personal experience combined with those of the interviewees." At the beginning of each interview, I told my own story as a way of explaining my interest in my research topic and as an attempt to form a link between myself and my informant. In some cases, the nurses responded to this with sympathy or, sometimes, by telling me of their personal losses. One nurse explained, at this point, that her own father had died when she was young, while another was drawn into my story to the extent of reflecting on the way in which my father's death must have affected me in later life.

My original assumption had been that respondents would reply briefly to my request in Part 1 of the interview for information on the jobs they had held since leaving school, with discussion of the

various influences which had brought them to work in their current hospice post emerging in Part 2. Although this had not occurred in the pilot interviews, almost all my respondents reacted to my request for information on their occupational history by telling me in considerable detail about their paths into their current work, so that it was frequently unnecessary for me to ask the question planned for Part 2 of the interview (asking them to describe their routes into hospice work). Many of them also talked in depth about issues I planned to raise in the final part of the interview (relating to the results of previous research) so that my interview guide proved to be very *much* a 'guide', and in most cases I had no problem in getting respondents to talk about their experience.

Fleming et al (2003:118) suggest that, to allow the hermeneutic circle to come into effect and to "facilitate the process of understanding", "the first series of interviews should be analysed before proceeding with the next sequence." In a study of nurses working with dying patients, Maeve transcribed and thoroughly read each interview transcript prior to the next interview. Units of data were identified and compared with units of data noted in previous interviews. "In this way" comments Maeve, "data analysis was recursive in that ideas, or units of data suggested by one participant were explored with subsequent participants. Because of this the interviews became increasingly longer and more focused" (1998:1138). During my own interviewing period, I made an attempt to allow the hermeneutic circle to operate by transcribing the interviews as soon as possible after I had undertaken them, and by using issues raised in earlier interviews to inform my discussions with later respondents. While this meant that the interview format varied between interviews, I was able to follow up ideas and hunches and to seek clarification on issues which were not clear to me.

Most of the nurses I interviewed were women, but a higher proportion of them than one would expect to find in the English nursing population as a whole were men (five). This undoubtedly related to the fact that the men to whom I spoke were nearly all older, more senior nurses who probably had greater autonomy and freedom to arrange their work schedules. My first two interviews (at Hospice 1) were both with male nurses and I immediately found myself questioning the wisdom of my inclusion of 'marital status' in the first section of my interview guide. While there is no evidence that I know of to suggest that male nurses are any more likely to be homosexual than men in the general population, I have myself encountered and been affected by the popular

notion that "all men in nursing are gay ". An entry in my research journal for 13 July 2006 observes:

"I've done my first two interviews. And would you believe it - these were both male nurses!? The first was my gatekeeper at [Hospice 1]. Both sensitive and clearly passionate about their work... right at the start of my interviewing journey, I'm hit between the eyes by the 'gay stereotype' bogeyman. I found myself wondering whether the questions would come out OK or whether I'd feel an awkwardness in asking them - or even dodge them altogether! In the event there was no problem whatsoever. Both men were married with kids, but Victim 2 and I had quite a discussion about the negative stereotype."

As mentioned above, only one of my respondents became upset at her interview. In early discussions, senior hospice personnel had sought assurances that I, myself, would be emotionally strong enough to deal with painful memories which might arise during the interviewing process. On one occasion, I did find myself becoming a little distressed. This occurred during my discussion with a female nurse who had postponed a previous appointment with me as she had had "a terrible weekend" in the hospice and needed to see her mentor for "reflective practice". I felt a particular affinity with this lady, and as she explained briefly why she had to postpone the interview I sensed her deep distress. When we did meet to talk, I found myself, for the first time, on the verge of tears as I explained about my husband's death. I later wrote in my journal (22 November 2006):

"One interview cancelled because she had "a terrible weekend" and had arranged to go for 'reflective practice.' This was the one lady with whom I did find my voice quavering in telling her about John. I said that I felt her pain the other day, when she'd so clearly been distressed by the events at the weekend - perhaps that had formed a link between us. She told me people always confided in her - the sort of person who inspired confidences. A lovely woman whom I'd be pleased to have as a friend."

Although I sent every respondent a copy of the transcript of their interview, only a small number returned them with amendments or clarifications. An interview I conducted with one senior male nurse was originally not intended to be used in my analysis (although he had a considerable

amount of in-patient hospice experience, he was currently working in the hospice community team) but he had specifically requested to talk to me as he, himself, had recently been reflecting on the question of why nurses went into hospice work. Because of this, I removed from the transcript a number of false starts, repetitions and hesitations. Having decided to include this interview in my analysis because of the interesting material it included, I returned the transcript to him in its edited form. Soon afterwards, he e-mailed me and pronounced himself "horrified! Do I really talk like that?" He had been so appalled to read the transcript of the interview that he had put it aside after a few pages as he could not bear to continue. The lady who (as I had recorded in my journal) had "sat eagerly on the edge of her chair to be interviewed, with a notebook open on her lap and pen poised, for all the world as if *she* was about to interview *me*!") sent back the transcript with all the 'ums' and ' ers' taken out and the illogicalities removed. I noted in my journal that I "wasn't too surprised and complied with her wishes because the changes didn't affect the sense of what she was saying" (Research Journal 9 June 2007).

I have always enjoyed interviewing, and my fondest memories of my first research job (investigating the potential for keeping elderly people out of residential care) are of tramping around the East End of London talking to elderly people in their own homes. The interviews for this project were no exception. An entry in my Research Journal for 13 July 2006 observes: "I absolutely loved doing those [first two] interviews. It helped a lot that both men were caring, reflective and likeable. I had no difficulty in getting them talking and a number of themes which tied in with my reading presented themselves beautifully." Of my third interview, I wrote that it had been "a joy - something totally pleasurable. It was like talking to a friend, though of course the only common ground we had was what we had time to share in that slim hour and a bit" (Research Journal 8 August 2006).

Patton (1990:353-4) observes that interviews "affect people. A good interview lays open thoughts, feelings, knowledge and experience not only to the interviewer but also to the interviewee. The process of being taken through a directed, reflective process affects the person being interviewed and leaves them knowing things about themselves that they didn't know - or at least were not aware of - before the interview." A number of my respondents made it clear that they had enjoyed being interviewed and had found it personally helpful. An entry in my Research Journal dated 26 November 2006 reads:

"Some [nurses] have said without prompting that they found it useful to think about why they went into nursing (and palliative care in particular) and I seem to have had no problems getting them to talk. Some of them - several - I felt I'd really like to have as friends. Perhaps there is something of the 'nurse manqué' in me! And perhaps that is one reason why I ended up doing this particular piece of research."

Data analysis

Qualitative data analysis is defined by Marshall and Rossman (1999:150) as "the process of bringing order, structure and interpretation to the mass of collected data." As with the choice of data collection methods, our method of analysis needs to be chosen with the aims of our study very much in mind. Green and Thorogood (2004:176) argue that one's approach to analysing data from an empirical study "is of course related to the aims of the study... [T]he broad aims will influence the *style* of analysis."

In hermeneutic phenomenological studies, observe Cohen et al (2000:76) analysis involves "moving from the field text, created by data collection, to a narrative text that is meant to stand alone for other readers". One of the most challenging tasks for the phenomenological researcher, suggests Koch (1999:27-8) is "to convey the story [by which she means our interpretations/understanding] in such a way that another person can share the understandings gained". The research products at which the phenomenological researcher is aiming, says Koch, involves "laying out one's comprehension of a text." It "tells others what it could be like to be in pain, or to experience fear. It offers the reader a different understanding, one the researcher hopes will illuminate a phenomenon, uncover an interest, or sensitize a health care practitioner to respond in a different or more appropriate way." The final research product should be "a story that the researcher has constructed and communicated effectively, with the ultimate aim of advancing our knowledge" (op. cit.:32).

In phenomenological research, the process of data analysis involves the researcher in bringing her own interpretive and intuitive faculties into dialogue with the texts of the interviews with

respondents. Setting out clearly the steps one takes in the process of analysing one's data is a vital part of the validation process in this type of research (Koch 1999:27-8; Mitchell 2002:24). Sanders (2003:293) observes that phenomenologists are "sometimes reluctant to focus on specific steps in the data generation and analysis process". Stanley and Wise (1993:60) note that the researcher's consciousness and experience is an "absolutely and totally central feature of any research process" which has a crucial impact on "how we interpret and construct what is going on". By setting out in as much detail as possible the way in which I undertook my data analysis, I hoped to "make apparent the part [I played] in constructing what goes on" (Stanley and Wise 1993:168).

Becker (1992:42) suggests that data analysis in phenomenological research "begins once the interviews are completed and the data have been transcribed". I do not concur with Becker and would agree with a number of other writers that data analysis in this type of research can commence with the first interview and continue, in different forms, until the research is finally written up (see, for example, Cohen et al 2000:76; Kalideen 1994:18; Kvale 1996:178; Yang and Mcilfatrick 2001:436).

I recorded some of my reflections on the data analysis process in my journal:

"Many writers suggest that data analysis starts at the first interview, and it's certainly true that there was a process of drawing on my growing understandings to shape and focus later interviews - allowing me to follow up hunches, test out insights, seek verification or explanation. So I could never claim all the interviews were "very similar" in terms of how I conducted them and what I asked - they weren't."

(Research Journal 5 July 2007)

While an ongoing process of analysis continued during the data collection phase of my research, a new, more formal phase of data analysis began once I had completed the last interview and began to think about attempting to synthesise and understand the rich texts I and my respondents had co-created. The analysis which occurs at this stage of a phenomenological research project may be seen to follow common steps. In the first phase, the researcher identifies the essential

characteristics of the data from each interview (Cohen et al 2000:76) which "involves some decision-making on the part of the researcher concerning what is relevant and what is not" (ibid). In the next phase of the analysis, the data are examined line by line and all important phrases "labelled with 'tentative theme names'" (2000:77). Passages with similar themes from different interviews are extracted and compared. Finally, the movement from identification and comparison of themes to a coherent picture of the whole "occurs through [a] reflective process of writing and rewriting" (2000:81).

Phenomenological approaches have been widely used in qualitative investigation by both sociological and nursing researchers. In terms of the ways in which phenomenological data should be analysed, however, by far the largest contribution has been made by psychological researchers. Crotty (1996:22) observes that many researchers who adopt phenomenological approaches have adopted "and in most cases adapted" methods developed by Colaizzi (1978), Giorgi (1985) and Van Kaam (1966). These approaches, notes Crotty (as well as those which draw on different sources for their method or devise their own) "display a common concern to derive *themes* or *categories* from the data, which coalesce to form a *comprehensive description* of the total phenomenon." (op. cit.:23)

Nursing studies which have based their analyses on the work of Colaizzi (1978) include Clarke and Wheeler's (1992) study of caring in nursing practice, Sanders' (2003) study of nurses' spirituality, and Webster and Kristjanson's (2002b) study of the experiences of long-term palliative care workers.

Steps in data analysis

In my own data analysis, I drew on the work of Colaizzi but the method I used to 'make sense' of my data was very similar to the method I had myself developed for the analysis of qualitative data in my previous research.

Step 1: Reading the transcripts

Once I had completed and transcribed all the interviews, I read each script through again to "acquire a feel for it" (Colaizzi 1978:59). I then re-read each transcript once more, this time using elements of the interview material to write a 'pen portrait' (Hollway and Jefferson 2000:70) to which I could refer during my data analysis to prevent fragmentation of the data and remind me of important characteristics of each individual such as key life events, previous work and previous caring experiences. (See Appendix 9 for examples).

Step 2: Extraction of 'significant statements'

During this stage of the analysis, I removed from the transcripts material which was not clearly related to my research questions or which I planned to record and analyse separately (for example demographic information, general discussion before and after the interview). The remaining material represented the 'significant statements' which would form the substance of my analysis.

Step 3: Identification of meaning units

From the 'significant statements' I identified individual 'meaning units' which I listed for each interview (for example "importance of time in hospice", "discussion with careers adviser").

Step 4: Listing of meaning units

Repetitions of meaning units were eliminated and the meaning units listed alphabetically and assigned a coding number (See Appendix 10).

Step 5: Coding

At this stage in analysis, some researchers, having identified individual meaning units on each transcript, either use a computer program (see below) to 'code' each unit or physically 'cut and

paste' similar meaning units onto individual pages. To avoid the fragmentation this procedure would have involved, I chose to write meaning unit codes in the margins of each transcript.

Step 6: Coding matrix

Individual meaning unit codes were entered on a matrix showing interview and page number to enable easy location.

Step 7: Clustering into themes

Individual meaning units were clustered into themes (for example, "School influences on choice of career", "Time: importance of").

Step 8: Constant comparison

Using a 'constant comparative' method (see, for example, Holmes et al 1997:94) I looked at all examples of similar meaning units within themes to develop an understanding of each theme.

Step 9: Development of description

Each theme was developed to allow description of part of the phenomenon being studied.

Several writers have commented on the fact that while they do have the advantage of producing large volumes of information, analysing data from qualitative interviews can be an extremely time-consuming process (Becker 1992:42; Marshall and Rossman (1999:110; Davies 1999:114-5). In the process of my own analysis, the initial 750 pages of single-spaced typescript were reduced a little by the extraction of 'significant statements' but the whole process took a great deal of time, and was sometimes very tedious.

Kvale noted in 1996 that over the previous decade, "computer programs have been developed to facilitate the analysis of interview transcripts. They replace the time-demanding cut-and-paste

approach to analysis of often hundreds of pages of paper with 'electronic scissors'." (Kvale 1996:173). These programs (which include NUD*IST, NVIVO, ETHNOGRAPH and others) represent aids for structuring the interview material for further analysis, but "the task and the responsibility for interpretation still rest with the researcher" (Kvale 1996:173). These programs do offer the researcher some advantages over manual analysis, including rapid access to all sections of text relevant to a topic or concept, ease of data-manipulation, transfer of data into Word documents, tabulation and counting (Davies 1999:203; De Vries 2007). There are, however, a number of disadvantages of using computer-assisted qualitative data analysis packages. Firstly, while they may save the researcher time in the final stages of data analysis, preparing the data and learning to use the packages can be very time-consuming (Davies 1999:204; De Vries 2007). Secondly, the prolonged sitting at a computer screen which is necessary to use these programs can be extremely tiring (De Vries 2007). Thirdly, the removal of 'meaning units' from the totality of their individual interview contexts (which I sought to avoid by coding directly onto the transcripts) could lead to a fragmentation of data. Hollway and Jefferson (2000:68) suggest that this problem of fragmentation of data is "perhaps the most significant weakness in computer-assisted qualitative data analysis".

My desire to 'keep in touch' with each individual respondent and my inability to spend long hours at a computer screen were my main reasons for deciding against the use of a qualitative computer package. My own method of data analysis may be time-consuming, but selecting and learning to use one of the available packages would also have taken time and I did not feel that I would have been able to remain as close to my data using a computer-assisted method.

The work of interpretation

Hermeneutic approaches to answering research questions necessarily involve interpretation on the part of the researcher. Ideally, the researcher attempts to verify her own interpretations within the context of each interview (Kvale 1996:145) and as far as possible, I did attempt to check out my own understandings with my respondents. However, I came to my research with a specific set of understandings and expectations which inevitably affected the way in which I analysed my data.

Where this is possible, some researchers attempt to add validity to their research findings by asking others to code their data independently (see, for example, Andrews et al 2008:50; Holmes et al 1997:94; Sanders 2003:295; Webster and Kristjanson 2002b:868). As a research student, I did not have access to a research team or resources to seek corroboration from outside sources, so I had to rely on the reproduction of extensive verbatim material to back-up my interpretation of my interview material.

Another method by which researchers may seek corroboration of their interpretation is to ask respondents to read these interpretations and comment upon them (Andrews et al 2008:50-1; Crotty 1996:23; Fleming et al 2003:115; De Vries 2000:39; Mishler 1986:126). The last stage of Colaizzi's process of analysis involves a "final validating step" which can be achieved "by returning to each subject, and, in either a single interview session or a series of interviews, asking the subjects about the findings thus far" (Colaizzi 1978:61). Again, my status as research student and the strict criteria imposed by the NHS Ethics Committee meant that I was not able to involve my respondents in my analysis - asking them to check the transcripts of their interviews and return them to me was itself 'pushing the boundaries' of my ethical committee conditions.

The final responsibility for interpretation remains entirely mine and another researcher considering the same research question might well have produced different results. The material on which my findings are based represent a co-creation by me and my respondents, but the final interpretation remains entirely mine. Fleming et al (2003:115-6) observe that while researchers drawing on Gadamerian philosophy might return to their respondents "in order to ensure rigour" they are ultimately "aiming to develop their own understanding of [phenomena]" and engaging in further discussion with the respondents might be a process which could "continue indefinitely" (2003:118).

Facilitating the hermeneutic circle

During the process of interviewing and data analysis, I attempted to allow the hermeneutic circle to come into effect in a number of ways. Firstly, I freely discussed with my respondents my own preconceptions and encouraged them to comment on them. My initial conceptions were not borne out but other significant themes emerged. Secondly, by transcribing recordings as soon as

possible after interviews and using insights gained from them to test out in later interviews, I was able to develop my understanding stage by stage. Thirdly, by "moving back and forth between individual narratives and the interviews themselves and generalisations about them" (Andrews et al 2008:46) I was entering the hermeneutic circle of interpretation in a "continuous back and forth process between the parts and the whole" (Kvale 1996:48).

Following Stanley and Wise (1993:6-7) I submit that my findings do not constitute a once and for all representation of a reality. As researcher, I was an active presence in my own research and constructed a point of view that is "both a construction or version and is consequently and necessarily *partial* in its understandings". As I see it, identity formation is, for all of us, an ongoing process - a process which is clearly illustrated in the narratives presented in Part 2 of this thesis.

PART 2

UNDERSTANDING HOSPICE CARE

Chapter 5: Understanding the process of becoming and being

The chapters in this section present the words of the hospice nurses who participated in my study. Their words represent the rich data on which I base my analytics of caring identity, focusing on two aspects of identity formation: acquiring a caring identity ('becoming' a hospice nurse) and enacting that caring identity ('being' a hospice nurse). Adopting a phenomenological perspective, I follow the nurses on their journeys from leaving school (when some chose to go straight into nurse training and others left to take other jobs or gain other experience) through their experiences in nurse training, their choice of specialty after qualifying as nurses and, finally, their move into hospice work. The narratives articulated by the nurses represent statements of identity and personal meaning; we are concerned here not with matters of 'truth' but with articulations of personal experience and the way in which individuals use retrospective accounts to establish their present identities. In Chapters 6 through 10, we observe the way in which the nurses describe having refined and renegotiated their identities to arrive at their present situations in ways that reflect how people in general ‘tell stories’ about themselves in the attempt to identify who they ‘are’. We observe the way in which experience and narrative interweave and inform one another in the establishment of identity.

Through the words of the hospice nurses interviewed, we move towards an understanding of what it is like to be a care-giver in the early twenty-first century. The retrospective narratives represent the nurses' attempts to make sense of, and give coherence and meaning to their life-paths and to maintain their sense of integrity and self-value. They provide insight into the ways in which individuals seek to resolve conflict between discourses of ideal nursing care on one hand, and of management-led, efficiency-based care on the other. Drawing on the retrospective narratives, we follow the process of construction of a 'hospice nurse' identity and examine the ways in which individuals seek for and attain personal integrity and self-value in the face of working environments which challenge their ideals and values[5] of care (their 'being-towards-care'). We look at the ways in which they make sense of what they have become in terms of what they have chosen *not* to become, revealing the processual nature of 'becoming' and 'being' a hospice nurse.

[5] By 'ideals of care', I refer to beliefs about how care should be given. By 'values of care' I refer to beliefs about underlying principles of care.

The confrontation between competing discourses relating to ‘ideals’ and ‘realities’ of health care can be seen to bring into focus the way in which nurses negotiate their individual identities through encounters with the requirements of everyday nursing. By setting the nurses' articulations in the context of discourses relating to developments in health care in the twenty-first century, we will be able (in Chapter 11) to relate their accounts of their very personal experiences to societal change.

In Chapter 6, we look at the nurses' accounts of their early choices of career, the age at which they had decided to enter nurse training, and alternative careers considered, taken up or rejected. Few of the respondents indicated that, at the point of leaving school, they had developed a 'nurse identity' and none that they had begun to explore the potential for hospice nursing. For a small number, their 'nurse identity' was recalled as having begun to form very early in their lives, but most would have to work through a process in which they attempted to find a job which harmonised with their 'being towards care'. By working in other jobs, individuals were able to test out occupational identities and to establish those which failed to meet their ideals and expectations.

Some of the nurses had, at the point of leaving school, aligned themselves with a broad occupational category (that of 'care provider') and had initially selected a different occupation within this category as a target but for various reasons had had to seek another occupation within the category which was both acceptable and possible for them to adopt. The fact that several respondents recalled an initial desire to become a veterinary surgeon indicates that for some individuals, the choice of nursing as a career is achieved through a process of 'occupational refinement' in which variations of a broad occupational category are considered until there is a match between personal aims, academic requirements and situational factors. For some of the nurses, the seeds of a 'nurse identity' appear to have been in existence at the point of leaving school, but to have remained dormant for varying lengths of time until changed circumstances or perceptions awakened them.

Talking about jobs which they could *not* have done, and recalling jobs which were tested out but found not to match their 'being-towards-care' allowed the nurses to identify and re-affirm their current identities as hospice nurses - in identifying what they were not and could not be, they were

emphasising what they were. We find here clear indications of a process of seeking jobs which would fit in with their 'being-towards-care'. In talking about the jobs they could not have done, the nurses are not only talking about what they could not *do*, but also about what they could not *be*.

What we find, in the nurses' articulations of their early career choices, is evidence of an *active* process of occupational identity-formation which varies considerably between individuals in terms of the time taken to embrace the identity of 'hospice nurse' and which may be an ongoing process through life, but which, in all cases, involves the establishment of basic ideals and values (here, a 'being-towards-care') and the search for an occupation which represents the best possible 'fit' with these ideals and values. We are able to observe that, for the nurses interviewed, the formation of a 'nurse-identity' is seen as having clearly pre-dated the formation of a 'hospice nurse-identity'.

In Chapter 7, we consider a wide range of factors which respondents recalled as having been influential in their personal experiences of 'becoming a nurse'. It becomes clear that, for most of the nurses interviewed, the development of occupational identity was recalled as having been affected by a wide range of external influences. On leaving school, many had had little idea of the careers they would like to pursue, and few had been certain that they wanted to become nurses. Thus it appears that occupational identity, for these individuals, was very much in a state of 'potential', 'possibility' or 'becoming'. The influence of other people (especially family members and teachers) is seen as having been particularly important in pointing the nurses towards some occupations and away from others, and for male nurses who had found it necessary to negotiate their way through the barriers erected by gender role assumptions, male role models appeared to have been particularly influential.

In this chapter, we find evidence of the early development of ideals and values ('being-towards-care') in terms of what one wants in a job and searching for a job to fit - a process of seeking occupational congruence.

In Chapter 8, we examine the nurses' narratives of the process of 'becoming a nurse'. Here we look at their descriptions of their experiences of nurse training, including their preferences for nursing specialties as students, teaching input on death and dying, and experiences of patient

deaths while in training. We look at the specialties they chose following qualification, and at their descriptions of their experiences of working in these specialties. The nurses' recollections of their years of training suggest that, during these years, they had developed their personal ideals of nursing care and identified core values by which to rate the quality of nursing care.

Various aspects of the training experience are recalled as having been influential in moving nurses towards hospice care (regardless of when the decision to enter hospice work was made). Negative role models (nurses who were seen to provide 'poor' or 'unacceptable' care), positive role-models, hospice placements and experience of 'good' and 'bad' deaths all helped the nurses to develop and refine their ideals of nursing care.

For some, experience of nursing specialties they had originally identified as attractive failed to match the images they had held of these specialties and to accommodate the nurses' 'being-towards-care'. Thus for some, working with sick children or babies proved to be more 'hi-tech' or more emotionally demanding than they had expected so was rejected in favour of other specialties in which the nurses could form close relationships with patients and provide hands-on care.

By working in other nursing specialties, the nurses were able to test out the extent to which their 'being-towards-care' could be put into practice. In some cases, nurses appear to have developed identities which were specific to specialties other than hospice nursing. These individuals may have worked in another specialty for some time, but reached a point at which either their own 'being-towards-care' changed or features of the working environment changed in such a way that it was no longer possible to nurse in a way in which they wanted to nurse. Other nurses moved more quickly through other specialties, in their search for congruence between their 'being-towards-care' and the occupational setting.

By the time they emerged from nurse training, half of the nurses had begun to assume a 'hospice nurse' identity, but widespread perceptions of hospice nursing as suitable for 'mature, experienced' nurses and pressures from senior nurses to obtain more general nursing experience had diverted most of these individuals into other specialties. For half the nurses, hospice nursing had not been an option considered at this point.

Gaining experience as staff nurses in other nursing specialties brought nurses' ideals face-to-face with the realities of nursing in the NHS in the twenty-first century. In articulating the factors that had been influential in moving them towards hospice care, the nurses frequently referred to aspects of their work which had 'pushed' them from the NHS into hospice care. These included an inability to provide the level and quality of care that they wished to provide, lack of time and lack of support for staff. Other factors, such as the focus on family care, pleasant working environment, multidisciplinary working and opportunities for relationships with patients were identified as having acted to 'pull' individuals towards hospice work.

In a way similar to that in which some of the nurses had 'tried out' other occupations early in their careers, post-training nurses were able to 'try out' different nursing specialties to seek congruence with their 'being-towards-care'. Having established a general identity as a 'nurse', individuals were now beginning to refine that identity, so that from seeing themselves as a 'nurse' they could begin to identify themselves more clearly as a particular *type* of nurse.

For those nurses who had not identified hospice nursing as congruent with their 'being-towards-care' by the time they completed their nurse training, 'becoming' hospice nurses involved a process of 'trying out' other specialties. Where these harmonised with their 'being-towards-care', individuals would remain in the specialty until there was a serious disjunction between ideal and reality. Where they did not meet individuals' ideals, they would continue to seek an environment in which harmony with their 'being-towards-care' was achieved.

In Chapter 9, we find the nurses moving towards the full development of a 'hospice nurse' identity and establish the ground against which the nurses began to form this specific identity.

A very marked feature of the interviews was nurses' perceptions of contrasts between care as it was given in the NHS acute sector (which embodied their 'not selves') and care as it was given in hospices (which fulfilled their ideals and offered occupational congruence). In talking about their rejection of care which embodied their ‘not selves’ the nurses drew attention to the process of identification as a specific aspect of identity formation. They contrasted the open, accepting attitude

towards death they found in the hospice environment with the acute sector's focus on restoring individuals to health and its tendency to deny the reality of death. Aspects of the working environment such as 'beautiful' surroundings, adequate staffing levels, emotional and psychological support for staff, the relative autonomy of nurses and having adequate time for patients were all referred to as attractive features of hospice work. The nurses also drew distinctions between the nature and quality of nursing care provided in NHS hospitals and in hospices. In hospices, nurses identified opportunities to provide 'good' nursing care in an environment which focused on 'care' rather than 'cure', which could make a realistic claim to be 'holistic' and where the 'task-focus' of acute hospital care was replaced with a different ethic of care, in which the meeting of individual patient need was the aim.

Clear distinctions were drawn between patient experiences of hospital and hospice care, and attention drawn to hospice's unique focus not only on patients but also on their families.

In articulating their dichotomous perceptions, the nurses were refining and affirming their own identities as hospice nurses. Identifying in NHS care aspects which failed to satisfy their own 'being-towards-care' enabled them to clarify their own 'hospice nurse' identities, in the same way that some of them had previously 'tried out' different occupational identities and later tested out different nursing specialty identities.

In the same way that they had identified occupations they 'could not' have done and nursing specialties they 'could not' work in, they were now making sense of their move away from NHS care and towards hospice work. And in articulating their negative perceptions of acute care and their positive perceptions of hospice care, they were not only stating what they could not *do*, but what they could not *be*.

In Chapter 10, I draw out five inter-related aspects of hospice nursing which seemed to be particularly meaningful to the nurses in terms of what it meant to be a hospice nurse: the opportunity to provide 'good' nursing care, the fact that hospice nurses could provide 'hands-on' (or 'basic' or 'bedside') nursing, the 'holistic' nature of hospice care, 'being there' for patients and the availability of time. These characteristics of hospice care appeared central to their identities as

hospice nurses and made sense of their continuing to work in the hospice environment. The 'good' nursing which was possible in hospices, and which had been an ideal to which the nurses had been aspiring and integral to their 'being-towards-care', was recognised by some as dependent on having adequate staffing levels, which ultimately depended upon adequate resources.

'Hands-on' nursing care (which, in today's NHS, is usually delegated to health care assistants, freeing qualified nurses to undertake more administrative and managerial tasks) was identified as one of the attractions of hospice care. It was not the tasks per se which were valued, but the opportunity hands-on care offered for nurses to fulfil their ideals of forming close relationships with patients. In the act of performing these tasks, connections were made with patients which nurses had found themselves unable to make in acute hospital settings.

Hospice care was also recognised as making a realistic claim to be 'holistic'. Such nursing care may have been an important ideal embodied in the nurses' training and assimilated by them, but their experiences within NHS settings had revealed a large 'theory-practice' gap which these nurses had not been prepared to tolerate.

In identifying the importance placed, within a hospice environment, on simply 'being there' - which they contrasted with the 'busyness' and 'doingness' of NHS acute care - the nurses emphasised the 'holding' nature of hospice work and drew attention to the need for this expression of care to be elevated to a new value. In 'being with' patients, nurses could transcend the requirement for 'effectiveness' and 'efficiency' which has become part of the ethos of hospital care to engage emotionally with those they cared for.

'Time' emerges from the interview data as a central, powerful and multi-dimensional theme. Time was seen as a pre-requisite for the provision of 'good' nursing care but as dependent on adequate resources, and while, in one of its expressions, time was plentiful in the hospice, there was also an awareness of urgency and of the need to 'get things right first time' for patients who were coming to the ends of their lives.

These five aspects of hospice care were particularly valued. They not only defined for the nurses what it was that hospices were able to offer but that NHS acute care could not offer, but also made clear the ways in which they, as nurses, were different from nurses working in hospitals. 'Being' a hospice nurse *was* being able to provide 'good', hands-on, holistic nursing care, 'being there' for patients and having time. These were the aspects of hospice nursing which allowed nurses to put into practice the ideals they had formed before and during their nurse training, but to which the realities of nursing in the NHS had presented apparently insurmountable barriers.

Through what might be termed the 'work of the self' - a process of identity-formation involving the development of ideals, the testing out of other identities until they managed to achieve congruence between these ideals and their working environments and working through 'embattled identities' - the nurses had arrived at a point of balance. In Maben et al's terms, they were 'sustained idealists'. The failure of NHS nursing to allow them to put their ideals into practice had not led them to leave nursing altogether; neither had they adjusted their ideals in order to continue working in an NHS environment they had found unacceptable. They had been uncompromising in their search for an environment in which they could practise their ideal nursing. For them, being a hospice nurse was being the nurse to which they had aspired.

Their current state of balance, however, was perceived by some of these nurses to be under threat, and the clarity of distinction on which the nurses had been able to call to mark out their current 'hospice nurse' identity was perceived as becoming challenged. The very financial restrictions which had turned nurses away from NHS nursing were perceived to be affecting hospices, so that they were having to become more attentive to the need for accountability. Increasing awareness of the availability of hospice care and improvements in diagnosis had led to higher levels of demand for hospice places and increased patient turnover. Hospice nurses were being expected to achieve the same levels of nursing care with lower levels of staffing, and time - which was seen as such a precious commodity in hospices - was not as readily available as it once was. Hospices, it seemed to some of these nurses, were becoming more 'medicalised' and more 'like the NHS'.

Such changes represent challenges to the nurses' identities as hospice nurses, and if the ethos of hospice care is eroded more and more, the point of balance the nurses have achieved through a

sometimes lengthy process of searching for congruence between ideals of care and an environment in which it is possible to live out these ideals will be seriously threatened. The nurses, who had first become nurses and who had moved on to refine their caring identities, will be forced to confront a serious challenge to their personal identities as hospice nurses.

Chapter 6: The initial process of becoming a nurse

This chapter examines the nurses' accounts of decisions made by them concerning their careers. At what age did they decide on nursing and when did they enter nurse training? What alternative jobs did they consider whilst at school, and if these were rejected, what were the reasons given for this rejection? For those who went straight into nursing from school, had they already formed an idea of the specialty in which they would like to work once qualified? For those who did not go into nursing training straight from school, what sort of jobs did they take? Finally, did any respondents undertake their nurse training at university or take another degree course and had any of them thought about going to university but decided against it? In the following chapter, the nurses' accounts of the various influences upon their career choices are examined in detail.

Age of deciding to become a nurse

Although 15 respondents indicated on the checklist a lifetime desire to do nursing (see Appendix 8) only seven of the 30 said at interview either that they had always wanted to be a nurse or had "never wanted anything else".

Emily had always wanted to be a nurse:

"I know I'd always wanted to be a nurse, ever since I was a little girl. I was very fortunate - having boys now who are having to decide what career path to take and what exams or degrees to study, and neither have a clue. I was very fortunate; I always knew exactly that I wanted to be a nurse."

AS "What sort of age were you when you first thought about it?"

EJ "As long as I can remember [SP][6] from a little girl [SP] and there are no nurses that I know of within the family, so it's an idea that I had, um, evolved myself completely. But I always wanted to

[6] [SP] indicates a short pause (approximately 2 seconds or less). [LP] indicates a longer pause.

be a nurse, and I've never regretted it, and I've always said that if ever I had girls, and they wanted to be nurses, I would have been delighted...[7]"

At primary school, Carol had dismissed her original idea of being a nurse when her headmaster encouraged her to think about becoming a doctor, but her A-level results were not good enough for her to apply to study medicine:

"... when I was five or six I wanted to be a ballet dancer like every little girl does. By the time I got to the age of 11, I did want to do nursing and I told the headmaster of my primary school and he said 'Why do you want to be a nurse? You've got the ability to be a doctor.' And from then on, that was what I wanted to be - a doctor."

AS "What age were you when you decided that nursing was what turned you on?"

CE "Well, I suppose it was before then - it was sort of seven, eight, nine, and then, from the age of 11 or 12, it was medicine until I did my A-levels."

Jenny was 15 when she decided to take a pre-nursing course:

"When I was 15 I was [SP] my father was moving again, and I said 'I don't want to move because I'm starting this pre-nursing course.' And I started that, and I did a pre-nursing course for two years, so I did human biology and everything geared [?][8] towards nursing."...

"I don't know whether they still [run pre-nursing courses] but a lot of people could leave school at that time at 15, and then there was the opportunity at this school to stay on from 15 to 17. I think - yes - I was seventeen and a half when I left, and within that, you did this course which was really good."

Graham was not sure what he wanted to do when he left school, but having met some nurses on his travels, decided on nursing in his early twenties:

[7] ... indicates omitted material.
[8] [?] indicates a word/phrase which was not clear.

"After school, I [SP] worked, um, for [SP] just as a sort of temp for nine months, really, to save money and then I spent two years travelling and, sort of [SP] well, spent probably a year travelling, and then ended up working in _____.So I did that for a year."

AS "And what were you doing there?"

GN "Bar work [SP] and [SP] after that I came back and just did, probably again, nine months to a year of sort of temp work - not really sure what I wanted to do - and then started my nurse training."

One of the 25 female nurses and two of the five male nurses interviewed recalled the decision to become a nurse as having been made with little forethought. Sandra had always wanted to do graphic design at school and briefly considered legal studies:

"... for my A-levels I [SP] well I had a [SP] for various reasons I dropped a couple, so for my A-levels I did English literature and language and I did art - that was going to be my career choice - art. "

AS "So you were going to do art originally?"

SI "I started doing graphic design - doing my work experience as graphic design."

AS "And how long had you felt you wanted to do that?"

SI "For ever - that's all I ever wanted to do"...

"When I left sixth form I went to [SP] I started college and I was doing law and psychology."

AS "A degree, was that?"

SI "No, it was just [SP] I was doing the A-levels at college cos they weren't on offer at my school, and did those at college, and then I kind of thought that maybe [SP] cos I've always been interested in psychology [SP] I kind of thought maybe that would be very interesting for me, and loved it and I thought, you know, I'll go into litigation or something, you know, some sort of criminal law - I was always very interested in it. And then I kind of had a bit of a setback in my personal life and couldn't go to college any more, and it kind of gave me like this massive rethink whether I was going to start the course again. And then I went to university to do nursing."

Mark decided on nursing at the age of 16 or 17, influenced by his aunt who was a nurse:

"I did art and the two Englishes at A-level, and I got good passes, but I just didn't [SP] I still didn't know what to do with them and it was a very good school - a grammar school - but [SP] I don't know. So I suddenly [SP] well, I know it was suddenly [SP] very suddenly said 'I want to do nursing. '"

Some of the nurses recalled that they had not considered nursing as a career while at school. Amy wanted to do a sociology degree and got as far as visiting various universities for interview but was not sure enough to pursue this path and went into nurse training after working in retail and taking a job as a nanny:

"... I would never have said that I would have ever made a nurse... I was always quite focused on doing something along [SP] sociology or that sort of thing. It always interested me, and I suppose in those days, we didn't have O-levels like that - psychology and sociology and all those things - they just weren't there. But I always enjoyed that aspect of things, so that's really why I [SP] but, you know, things happen. You take one path and then you get diverted off."

Nursing was not something Christine considered at school. She had undertaken work experience in a hospital but had been put off because the nurses she had observed had not been "hands-on":

"... one [school friend] has become a doctor, and she was considering that from about age 15 and we both went to a careers talk about, um, the medical professions - NHS professions. Um [SP]

another has since become a nurse, but, er, there wasn't anything about it at the time. So it wasn't really on the agenda at all."

Age of entering nurse training

Table 4 shows the ages at which the nurses had started their general nurse training.

Table 4: ***Age of entering nurse training***

From school: No pre-nursing course	10
Mature (20s)	9
From school: Did pre-nursing course	4
Mature (40s)	3
Mature (30s)	2
From other experience (age unspecified)	2

Around half of the respondents (14) had gone straight from school into nurse training, of whom four had followed a pre-nursing course while still at school. Half had done other jobs before commencing their nurse training, with most of these starting their nursing courses in their twenties and a few beginning in their thirties or forties.

Janet started her training at 23, having left home at the age of 17 following her GCSEs and having worked in various office jobs:

"I started when I was 23... I think I was 22 when I did the entrance test and then I was about [SP] I think [SP] I was 23 when I started [inaudible]. So that was about ninety-one."...

"... I was one of the older people in the [SP] I was only 23, but I was one of the older sort of people, and that gave me more confidence as well."

Marion was in her late forties when she started training to become a nurse, having been made redundant from her catering job and taken a job as a nursing auxiliary at a hospice:

"And _____was my ward sister, and I was continually wanting to know more - why the staff nurses used that medication, how they did injections, what caused high blood pressure, low blood pressure, what makes people sick - all those sorts of things. She'd [laughs] she'd laugh, and she'd say 'Oh, I think you should go off and train' [mutual laughter] and I said 'Well...' I thought I was probably too old, so she said 'Well you won't know unless you find out.'"

AS "How old were you at this point?"

MH "Forty nine."

Preferences for nursing specialties

It was clear from the interviews that the vast majority of the nurses did *not* go into nurse training with the intention of working in a hospice setting (the one exception being Marion, who had worked as a nursing auxiliary in a hospice and entered nurse training in her late forties) and also that few had had a clear idea of the specialty in which they would like to work on qualification as a nurse. Steffie, who had trained as a nurse in Australia, had always enjoyed working with children, and originally wanted to work in neonatal intensive care but was put off by a training placement:

"I did get careers advice, and my careers adviser advised me to try out, um, childcare and I spent four weeks in year [SP] before we start our [SP] like our A-levels [SP] we do a work experience placement, and you get eight weeks of work experience placement and the idea is that you spend a small amount of time in different areas to get different feels of things if you don't know what you're doing. If you do know what you're doing, then you go and just do that, and I said I wanted to be a nurse and a careers adviser said, 'Well, we can get you four weeks placement at this hospital and' [SP] which was close by, and she said 'And we can get you four weeks placement in another area.' She said 'If you want to try childcare' [SP]. Cos that was the only other thing that I could think of at the time that I would be interested in. Considering that I wanted to do neonatal intensive care babies, I thought [SP] or nursing to do with children, um, so I did a child-care placement as well."

Working with children was also something that attracted Grace, who also found during her training that this did not suit her:

"... I always wanted to go into childcare, from a very early age. And my original plan was to start my nursing and then do children's nursing. But once I worked on a children's ward, I realised that I couldn't do it long-term [SP] I would be too [SP] it'd be too emotional. I just couldn't have coped with [SP] you know, sick children, on a [SP] on a regular basis, so I just stayed with general nursing."

Other career options considered, rejected and chosen while at school

Of the 14 hospice nurses who went into nurse training without having other jobs first, four did a 'pre-nursing' course. These courses were usually provided within a school or college setting for students who had decided on nurse training and included GCE O-levels which were considered relevant to nursing. Elaine considered becoming a vet or doctor, but felt that she did not have the necessary academic ability and was told by her parents that they could not afford to send her to university:

"I went to college, and I did a pre-nursing course - that was up in ____at ____."

AS "And how long was that?"

EA " That was a year, and what you did was, they kind of [SP] they sent you on a few work placements, which was great experience, because you didn't just do nursing - they sent you off to special needs schools, and [SP] special hospitals and things like that, and it was [SP] you know, specialist units really. And that was really, really good experience, at the age of 16 - you know, it made you grow up pretty quick seeing what you saw. And at the same time, they gave you the O-levels that you needed to get into nursing..."

Diane's parents had no high hopes for her academic attainment and she did not feel that she could attain a great deal at her secondary school. Finding a technical college which ran a pre-nursing course opened up new possibilities:

"It was a year-long course and they [SP] and they just got you [SP] and they helped you with [SP] they advised you on how best to apply to the various places. We didn't learn anything about nursing, but we did the basic, um, O-levels that would be considered to be appropriate."...

"... I found this, um, ____ in ____, a technical college that did a pre-nursing course. I've no idea how I found it, because we didn't have the Internet in those days, but I heard about it and I thought 'That's what I'll do. I won't ever do anything here.' So I remember saying to my parents that I wanted to go there, and they took me for an interview and they accepted me, and that meant that they didn't have to pay fees any more [laughs] and I might get some qualifications, which I did, so [SP] And they were very surprised when I got those O-levels. I only got four or five altogether, but they were very surprised and made it very clear that they were surprised."

Of the 16 nurses who did not go straight into nurse training from school (or from doing a college-based pre-nursing course) 11 went into other jobs, three embarked on other courses of study and two undertook other experience.

Some of those who went into other work from school worked either in caring jobs or within a health-care setting. Gordon, whose father was a doctor, began his training at the age of 21 having first worked in various posts in a hospital setting:

"Well, I trained at the ____ Hospital. This was at the ____Hospital, in ____, so [SP] but also, other ____hospitals like the ____and that [SP] so I worked in medical records and different things, so got a feel for the hospital. But it was actually while I was working as a ward clerk at the ____that it sparked my desire to go into nurse training. It was because of the contact with patients and families, which you often get with ward clerk sort of duties [SP] um [SP] that made me decide to go into nurse training and I was [SP] you know, remembered that it was a fairly sort of um sudden

decision in the sense of 'Yes, I want to do this.' So that's when I applied to the ____Hospital - we lived about a mile away - and trained at the ____Hospital. [SP] I did my training there."

AS "So you'd been working since you left school? How old were you when you left school?"

GW "Eighteen. Yes, well I was doing these various jobs in the hospitals, you know, portering and medical records and ward clerk and different things."

Amy left school after doing her A-levels, having dropped the idea of doing a sociology degree, and worked first in a shop where she had had a Saturday job before becoming a nanny:

"... I did my A-levels and, I, um, wanted to do sociology and I went to a few interviews at various places. Um [SP] but then I decided that [SP] perhaps it wasn't quite for me at the time and I just wanted to do something different and not keep studying - just have a bit of a break really, I suppose. And that was [SP] I always had a Saturday job in ____so I um [SP] I went back to that [SP] I went to that and started working full-time there, and then while I was there, I thought well, it's not what I wanted to do all the time so I applied for a nanny post and I became nanny to a family in ____. And that was [SP] I really enjoyed that."

Other nurses had left school and gone straight into jobs which had no obvious connection with nursing or other caring professions. Jonathan's father was a painter and decorator and as he had been helping him in his work from an early age, it seemed natural for him to follow his father into the trade:

"... I had O-levels, and several CSEs, but one was equivalent to the GCE levels. From there - from school - I went into painting and decorating, then into, sort of a bit of building, then to a driver, then back to painting and decorating, then in '88, I moved into the RAF as a fireman... I wanted something a bit more exciting than watching paint dry - literally. So I moved into that. I was in that for five years. Um, came out of the RAF - purchased my discharge, because they were actively getting rid of firemen... I actually went to theological college, because at this point, I'd decided I was

going to become a medical missionary. Did three years' theological training... At the end of all that, I decided that, er, I didn't want to go in for ordained ministry."

Kerry's parents wanted her to do typing at school and when she left she went into office work but quickly decided it was not for her:

"... when I did leave school I did go into secretarial work, and ended up in police stations [SP] more legal [SP] and I remember the one day I thought 'No, this isn't for me.' And I'd been doing [SP] yes [SP] so I left school at 16, and I think it was about [SP] I was 17 [SP]18, yes, I think I was eighteen and a half and I thought 'No, this is not for me.' I went to the library and I looked up nursing to see what do I need to get into nursing and that's how it all started."

Options, dilemmas, choices

Some respondents remembered having been aware from an early age that they wanted to do work of a caring nature. Carol felt that her choice of work was related to the fact that she had been brought up as a Quaker:

"Well, my primary motive was to get a qualification that would be useful overseas... but I suppose a secondary thing is, um, a caring profession. I'd been brought up as a Quaker [SP] you know, that was the sort of thing I was orientated towards. I'd already done community work - you know, I'd never had any leanings to do anything other than something in the sort of caring line."

Some found themselves, at various points in their lives, facing dilemmas over whether to become a nurse or to do some other kind of work. After working in various jobs, Matthew took a postgraduate certificate in the education of adults:

"... so I finished [studying for the certificate]. Then I took a year or so out when I went to New Zealand. I worked as a farm worker and so on, and that was when I made up my mind to go into nursing. And I was really in a dilemma, because I would really have quite liked to have done farming. I enjoyed that enormously and I was very torn. But that was the end of the sixties... you

know, one was engaged with people, so I said 'Do I want to engage with people or, you know, live this lonely life looking after sheep, cattle or whatever?' And I opted for people - probably a mistake, but... so I decided to come back to England and trained in England."

At an earlier point in her life, Christine found herself having to make a decision between doing an English degree and doing nurse training:

"My Mum, before I did my English degree and I was talking to her about, um 'Maybe I'll do [SP] I don't know whether to do the nursing or not or whatever' when I'd done that work experience, and didn't really [SP] it didn't really enthuse me [SP] er, she said 'Well, maybe you could do the English degree and then do nursing later if you want.' So she was very, you know, relaxed about that [SP] you know ' Do your degree and, um, we won't [inaudible] say you've just wasted three years.'"

Four of the nurses had considered becoming a veterinary surgeon. Elaine thought about becoming either a vet or a doctor but opted for nursing when her parents told her they could not afford to send her to university:

AS "When did you first think [that you wanted to be a nurse]?

EA " Um [SP] I don't know. I was quite young [SP]. First, I think, it started off with a feeling of wanting to look after sick animals, and so I wanted to be a vet, but as I got older I just thought 'I'm not really clever enough to be a vet or a doctor, so I'll be a nurse' and then my [SP] my parents had already said that they couldn't afford to send me to university, cos I'd already said I wanted to be a doctor and they'd said 'Well, we can't afford to send you to university.'"

At school, Catrina could not make up her mind whether to do physiotherapy or nursing and only made the decision when she got her A-level results and had to choose between the courses on offer:

"My whole way of [SP] when I was applying to go to university... I fell into nursing by accident - it completely wasn't on my mind... I don't know... nursing just came in [SP] I actually don't know

where it came from but on my UCAS form I wrote three options for physiotherapy and three for nursing and physiotherapy was actually my first choice, and nursing, you have to have first and second just in case you don't get into your first place. And I'd actually got into my first place [SP]. The day you get your results, you have to ring up and then they tell you if you've got it or not, and I got into my physiotherapy and just that day I thought 'Do you know what? I actually want to do nursing.' And I declined that place and I accepted the nursing offer.... I didn't know what nursing involved.[SP] I'd never worked in health care in that way."...

"See, I came into nursing by mistake in a sense... cos I never had any hard and fast plan - 'this is what I want to do'."

Other jobs considered by respondents were hairdressing (Alice), graphic design (Sandra), journalism (Felicity) and teaching or childcare (Steffie).

Several of the nurses referred to specific careers or types of job which held no appeal for them. Four specifically said that they would not have wanted to have gone into teaching:

"... my mates about the same age as me, a lot of them went into the sort of teaching and I'm the only nurse one, actually - a lot of them went into the sort of teaching and some did medicine and stuff like that, but all of them are sort of 'God, I admire [SP] you're doing so much...'. But to me, I'm sort of, I couldn't be a teacher, and them doing that is like sort of 'Wow!' To me, but then I sort of add on the fact that [SP] the nature of the job I do, and they think I'm God in person, really, because they don't see how [SP] how it's possible [SP] to be honest."

(Marina)

Three said that office work in general had not been an attractive option. Graham had found himself being steered towards "traditional" jobs such as accountancy but doing temporary office work made him realise this sort of work was not for him:

"... I did fairly well at school, and, you know, I had got good grades, and so a lot of my friends were going to university, um, but I... didn't want to go straight into further study. Um, so I kind of branched off there, but I think up until that point, you know, kind of the choices I'd made in subjects and things had been gearing me towards something like, you know, accountancy, something like that, and I think just doing sort of temp work in offices, I just thought 'Actually, there's just no way that I could do this kind of ' [SP] you know, 'This isn't what I want to do. I don't want to be stuck in an office all day', um, so it's just a case of, you know [SP] I think [SP] you know I think once that sort of traditional route - or the route that sort of was planned out was taken away, it was a long time to then think, OK, if it's not that, then what is it?"

Felicity had wanted to be a nurse "on and off" throughout her childhood, but for a while, considered doing journalism - a career her grandfather had followed and which he was keen for her to take up. In the end, however, she rejected the idea of journalism, identifying it as failing to fit in with her own values:

"I'd sort of thought about [being a nurse] [on and off since childhood] and was going to become a journalist."...

"I didn't really have the motivation to do journalism. You have to be very sort of motivated [SP] it's a very different world to [SP] to what I want to do, so I..."

AS "What was different, do you think, about it?"

FY " Well, it's a very uncaring world. And that's [SP] you have to be very ruthless and that sort of thing, so..."...

"... as I got into my teenage years I was looking at sort of more glamorous careers [SP] to move into journalism, and things, and I think [SP] what happened was that my uncle became very unwell and had a brain tumour, and, um, that sort of started me to thinking back into nursing again and actually [SP] So while he was unwell... I applied to go into nursing..."

Six respondents (including two men) said specifically that they had not wanted a career in medicine. Matthew, whose father had worked as a doctor, had not found the medical world an attractive one:

"Well, my father was a GP - my mother didn't work... I never wanted to be a GP like my father. I never had any desire to have anything to do with the medical profession. He used to work, you know, 12-hour days, I hardly saw him as a child, and I thought he had a horrible life, so I didn't want to do that, you see. Too big a commitment, maybe."

For Carol, nursing was much more in tune with her own interests and inclinations:

"... I realise now that if I had the choice again, I would never want to do medicine because I think what nursing is about is much more what I'm interested in and is much more versatile, actually, than medicine."

AS "What is it, about medicine, do you think, that turns you off?

CE " [SP] I think it's quite limited in many ways. Um, I mean, career-wise, you have to set off quite early on in your career and not deviate from that, and there's a big thing about, you know, getting to the top of the tree if you possibly can - huge competition - there's a lot of [SP] well, depending on which specialty you go into [SP] a lot of mechanical things involved and I don't think - with the possible exception of palliative care medicine - you don't really [Inaudible]. Doctors are fairly focused and regimented and one-dimensional and I'm not saying that we don't need doctors because we do, but I think that generally nursing has much more interesting potential and it certainly has for me personally."

Carol saw medicine as "high-tech" and as a career which would not facilitate career breaks to allow women to have children and return to work:

"... over the palliative care question, one of the things which I don't like, and I'm quite frightened of, is high-tech stuff, and I knew if I came into palliative care I would be able to avoid that kind of stuff.

I don't [SP] it was one of the reasons why I didn't particularly want to be in medicine, because I'm much more interested in the care and communication side than I am about being, you know, a kind of high-tech wizard and managing to do all these things that actually give nursing quite a lot of kudos I think, and medicine also, because surgeons are very highly regarded, aren't they, and that [inaudible] dexterity and technology writ really large. I wasn't interested in all that."...

"... you're a nurse and then you have your babies and then you, you know, give up work and stay at home, or it's perceived as something that you can come back to later, but medicine isn't - or wasn't."

While working as a nurse, Mark was offered money by the grateful brother of a patient to train to become a doctor:

"For a while [SP] at ____, I toyed with the idea of switching careers and becoming a medic, and I'm not sure now whether [SP] cos I was given an opportunity to do it. I met [SP] I nursed a man whose brother offered to pay for me to become a medic. He couldn't understand why I wasn't a medic - he just [SP] he couldn't understand it. I couldn't get through to him why [SP] well, he could understand what I was doing as a nurse, cos he particularly liked what I'd done for his brother, but he just thought it was crazy [SP] that my skills were wasted, as he said [SP] so he wanted me to become a medic. And he was [SP] he was influential at St ____'s, because you could still buy [a place at?] medical school, so he was going to buy a place for me [inaudible]. But [SP] I did think long and hard about it, and decided no - I'm a nurse. And I think it's very pompous of me to say this, but it was at that time I thought about it [SP] I was made to think about it, and I know it's a pompous thing to say, but on my tombstone, all I want written is the word 'nurse' cos that's [SP] you know, what I am."

Going to university

In recent years, nurse training in England has moved into the higher education sector where, currently, students opt for either a diploma or degree course. Prior to this, nurse training was

provided by schools of nursing and nursing students were included in staff numbers on hospital wards.

A small number of respondents said that they had undertaken their nurse training at a university. Catrina had had no doubt that she wanted to study at university:

"Oh, I definitely wanted to go to university. All I knew about my course at university was that it had to be a degree and a three-year course and I definitely wanted to go to university cos you know, my sisters hadn't gone, which I think is a real shame. I don't think they should have had kids and got married. I don't know, but they should have explored their own lives a bit more. So [SP] and also I feel [SP] my mum and my dad came over here so that me and my sisters could have a good education as well, and I [SP] also everyone says if you've got education you can't lose anything - you can always do something, can't you?"

Stella did her training at university at a time when entry to nursing via a degree course was relatively unusual:

"I started training in [SP] 1982 at the University of ____, and I actually did a B.Sc. in nursing which in the eighties - the early eighties - was unusual. There weren't many degree nurses then, although now it's [SP] it's fairly established. All of the nurses now are diploma or degree nurses when they go in their training, but then we were quite different, so I was [SP] I was in the minority."

Two respondents had gone to university before undertaking nurse training but studied subjects other than nursing. Carol went to university to study sociology:

"... originally I was going to do medicine, and then I knew, firstly [inaudible] that I wasn't going to [SP] that I didn't have the temperament to be a doctor - I was too much of a worrier - but also that I wasn't going to do well enough in my A-levels either, because I did science A-levels but I'm not particularly good at science. So I got them, but I didn't get good grades and by then I'd decided that I wanted to do social science so I did a sociology degree."

Christine took an English degree before doing nursing. She was active in the church while at university and it was the university chaplain who had first suggested that she might consider hospice nursing once she had qualified:

"Well, I know when [hospice nursing] was first suggested to me, and that was when I was applying for my nursing training and, er, I was doing an English degree at university at that time, um, and the university chaplain was, um, going to do one of my references. So I chatted to him, and he said, um, 'Have you ever considered hospice nursing?' And I never had but that just stayed with me."

A small number of other respondents had taken degrees in various subjects after completing their nurse training, including psychology (Matthew), geography (Susan), health studies (Janet), health services management (Gordon) and community health (Kerry).

Alison had wanted to be a nurse since childhood. At the time when she completed her A-level studies, nurse training was not yet university-based and she resisted persuasion from her parents to go to university:

"... it's always been on the forefront of my mind that it was what I wanted to do. My parents, at the time of 18, once I'd done my three A-levels, really tried to persuade me to go to university, but I just wasn't interested - I wanted to go into nursing, and in those days[9] you could go into nursing without a degree - I mean you just didn't have to do that."

Mary's two brothers and one sister all went to university. She, however, had decided at the age of six or seven that she wanted to become a nurse and she was not discouraged from this path by her headmistress:

"The headmistress [at my school] was very strict - a Scottish headmistress, who was very keen that girls should go to university, and in those days that was very [SP] that was quite sort of advanced. You know what I mean? And, um, so I was one of the few that didn't go to university. But that was fine. I was [SP] you know, [nursing] was very much encouraged as well..."

[9] She started her nurse training in 1980

For Alice, there had never been any question of going to university and her original plan was to become a hairdresser:

"... I was brought up in a village, very sheltered and really we weren't taken out into the world at all. We didn't go on holidays and things like that, so it was very, very sheltered. And I was going to be a hairdresser because I didn't [SP] didn't really have any [SP] I mean we weren't encouraged to do university or anything like that. I mean it would never have occurred to anyone in the family because nobody did that sort of thing and it was [SP] in those days very few people went to university and we were both girls in our family as well, so I don't think really there were any big ideas of what we might do."

Chapter summary

In this chapter we find evidence of the beginnings of an active process of occupational identity formation. Some of the nurses had already begun to assume a nurse identity by the time they left school, but most went through a process of testing out other careers to establish the extent to which they fitted their developing occupational ideals and values. Identifying in their narratives careers they 'could not' have done enabled the nurses to affirm their own established occupational ideals and values. The nurses' narratives made clear that the vast majority of them had not entered nurse training with the intention of doing hospice work and, indeed, had no clear idea of the specialty in which they wanted to work on qualification.

The next chapter examines the various factors which the nurses felt had influenced them in their choice of career.

Chapter 7: Factors influencing the process of becoming a nurse

In my attempt to access the structures of meaning embodied in the nurses' narratives, I found that seven groups of factors were recalled by the nurses as having influenced them in their choice of nursing as a career: individual/psychological factors, parental/family influences, other people's influence/societal expectations, factors related to schooling, images of nursing, pragmatic factors and lack of planning/chance.

Individual/psychological factors

Psychological factors

Mary felt herself to be less "academic" than her three siblings and felt that her choice of nursing might have been related to a need to make her own mark:

"I have two elder brothers and a younger sister who all went to university, and two of them were exceptionally bright. The third was very, very bright but more sensitive, and I was the least academic of the three [sic], so maybe I've done it in compensation. This makes me feel important too. You know, way, way back. I'm not talking about now, but maybe I made that decision when I was young because this was my way of thinking 'Well, I can't compete with my siblings, so I'm going to be doing my own thing.' I do have parents, though, who are very much caught up in caring themselves, and so they were always terribly proud of me, especially when I became a ward sister. They used to [SP] you know, they made me feel good because they would tell their friends 'Oh, our daughter Mary, she's [SP] we are as proud of her as we are of any of our siblings [SP] er, children.'"

Elaine's parents did not actively encourage her in her choice of nursing, but she felt that her choice related partly to a need for approval from them and from her grandfather:

AS " What about your parents? Did they encourage you at all?"

EA "Not really. They just kind of went along with it. I think it was very sort of give you a backhanded compliment, really: 'Well, you realise that you'll have to work a lot harder than you do now?' um that sort of thing, you know. It was very sort of, um [SP] backhanded, really. But then, I'd grown up with that anyway, so it didn't really [SP] by that time it didn't really bother me. I suppose it must have done at some level, because I was constantly looking for their approval, but I think that it, um, kind of just went over my head, really. Because I didn't [SP] because I hadn't actually had to work that hard to pass things - I just was lazy at school, I think"...

"My [mother's] Dad always used to say to me, from quite a young age, 'Every day, try to do something that you're proud of.' And I think that's one of the things that has... And I think I tried [SP] I really want him to be proud of me [SP] and his [SP] his adoration, or his approval, if you like, is far more important now than hers is, even though they're both now dead [SP] because I felt that he had the guiding wisdom, and she didn't, really."

Diane remembered having enjoyed her nurse training and the feeling it gave her of being "needed":

"... I absolutely loved my training. I was so excited, because I was with people and people really needed me [SP] 'Nurse!' You know [SP] and I was good at it. I got the hang of it really fast and I got the hang of, um, getting to mix with the groups. I always got to know what the ward sisters liked and wanted - and did it, you know. And, um, I was very good at obeying the rules and I loved it - you know, I just adored it."

Aims and desires

Several respondents indicated that they had looked for a job in which they would "work with people" or which would offer contact with people. Gordon, whose father was a GP, started nurse training at the age of 21 after doing various jobs in a hospital setting:

"... [I] never [had] a desire really to do doctoring, but it was the contact with people. [SP] I'm quite a people person and wanted to, you know, develop careers in that so..."

Felicity said that she had gone into nursing "to care" but suspected that this was not necessarily true of people currently entering the profession:

"... speaking to one of the lecturers, she was saying today that actually they're coming into nursing so they get a job rather than anything else, whereas I thought you should come into nursing to care, and that's why I came into it, because I cared for people, not because [SP] you know, for any other reason."

Emily felt that nurses in general obtained much satisfaction from caring for others:

"I think a nurse is possibly a certain sort of person who gets a great deal of satisfaction out of caring for others. It could be in a chemotherapy setting, it could be in a geriatric setting, the different areas require different skills. But... I don't think we're [palliative care nurses] any different - we're much of the same mould."

When Hazel first thought about nursing, it represented an opportunity to develop her understanding of illness:

"... my father died when I was 14 and he had motor neurone disease, and at that time very, very little was known of that disease. I can remember going to the _____ Hospital and seeing him deteriorating and so on, and it was extremely distressing for the family... I don't know that I even thought about [doing nursing] at 14 [laughs] I couldn't have done [SP] I was too upset at the time. But I [SP] my overriding feeling was that I just wanted to know more about what happened when people were ill, so that we wouldn't be so devastated again in the future of not knowing what to do, and just being at such a loss. So I suppose that was why, you know, I was thinking about nursing and of course, when the school channelled you that way [offered a pre-nursing course] and my friend that I started school with is very academic and very clever, so she was going on to Bristol University, and [SP] but I felt that with my mother having been left as a widow that to do nursing was the better career for me because I was going to be paid as a nurse, whereas to go to university, she would have needed to have had more money available, basically, so it all fitted in, really, with what I wanted to do."

Patricia had wanted to become a nurse while at school, but her boyfriend had dissuaded her from applying for training, complaining that she would end up working shifts and he would seldom see her. After doing a series of office jobs, she managed a GP practice but became dissatisfied and nursing represented an opportunity to do a more satisfying job:

"My mum died in 1999 and she was very unwell the previous [SP] that summer. [SP] She died in November and she was very poorly in the summer. She lost a lot of weight and I went to see her in the summer and we went to see her in hospital. And she came home, and she was recuperating at home, and we had a conversation where she said to me, you know, 'What are you going to do?' And I said 'I'm really [SP] I'm really fed up with my practice managing.' It paid great - the salaries are phenomenal - but I wasn't happy, I was working God knows how many hours. I felt my relationship with my daughter wasn't as strong as it might have been, and I just said 'Mum, I want to do something else'... Then she said 'Why don't you go into nursing? Have you never [SP]'. You know, she said ' You always did want to do nursing.'"

It was a desire to work with children that led Grace to apply for nurse training (although she later found herself less enamoured of this aspect of nursing than she had expected to be and opted for another specialty):

"... I think after my dad died [when she was 10] I thought more about it, and um [SP] but I don't really think that was a big influencing factor. [SP] Initially, it was the children's aspect of nursing [SP] I wanted to work with children and that was what led me into nursing."

Barbara, who started her nurse training at the age of 40 after various office and caring jobs, had no particular career ambitions at school:

"... because I was good at languages, I was always pushed in that direction, but I wasn't really interested, to be honest [laughs] so [SP] so [SP] no, I mean I was [SP] I don't suppose there was anything wrong with it, really, but I remember wanting to leave school and get married and have children, and that's basically what I did."

A desire to be "helpful to others" was the most highly rated factor on the checklist completed by respondents after interview, with 83% of those who returned a completed checklist rating it '4' or '5' (see Appendix 8).

Congruence with subject interests

Two of the nurses recalled choosing nursing partly or wholly because it was congruent with their subject interests. Elaine remembered having been attracted by the prospectus for a pre-nursing course:

AS "Can you remember when that thought [of being a nurse] first occurred to you?

EA "I was in my teens. I think it was looking through the prospectus for the colleges. I think it was that. I was [SP] I thought 'Oh, that looks like a really interesting course.' Cos I'd always been interested in [SP] it sounds a bit morbid [SP] but when we did biology at school and did dissections of mice or rats, or whatever they were, and frogs and things [SP] they fascinated me - absolutely fascinated me - and I just thought 'Well, that looks like a really good course.' Cos it involved a bit of chemistry, biology, sociology and English language."

Religious/spiritual beliefs

Only a small number of respondents indicated at interview that religious or spiritual beliefs had influenced them in their choice of nursing (though this was mentioned more frequently in relation to choice of hospice nursing), but ten (34% of those returning a completed one) gave a high rating to "spiritual/religious beliefs" on the checklist (see Appendix 8).

Personal experience

Working in a caring or health-related job was mentioned by several of the nurses as having represented a progressive move towards nurse training. Janet, who started nursing at the age of

23, had undertaken voluntary work and had worked during her school holidays in her aunt's nursing home:

"When I was doing the clerical work, I did a bit of voluntary work. Um, like I did a course for people with learning disabilities and then [inaudible] a sort of befriending scheme and did that for a while. And I used to sometimes help out at sort of soup kitchens - not for long, but just for a little while. I did a few things... When I was 16 as well, my aunt had a nursing home, and I used to, um, help there in the summer holidays, just sort of giving people their lunches and things like that."

AS "Where did that fit into your thinking on doing nursing?"

JF "Um, yes, it just made me think I want to do [SP] that that's what I'd like to do..."

Marion undertook nurse training as a mature entrant, having worked in the catering trade and having worked as an auxiliary nurse after being made redundant:

"My husband and I had both been in the catering trade and, through no fault of our own, were made redundant because we were managers for a company. And we came back to our house in ____and took a little while to recover really, because it's quite a shock being made redundant. And then we had to think about employment, so I saw an advert for a job, a vacancy as an auxiliary nurse, in ____Hospital, which is a small community hospital, mainly looking after people who have come out from the acute hospital sector and they need a little bit of physiotherapy, rehabilitation, that sort of thing, before going home."

Marion did not get that job, but was offered a similar job at a local hospice.

Other respondents mentioned having adopted caring roles in childhood. Angela had looked after her mother:

"My mother was old when she had me [SP] I say old, she was older - she was 43 when she had me. I was the sixth child - the fifth girl, um, and I think I was always with her... I think I grew up sort

of looking after her - you know, an older mother. By the time she was 60 I was 17, and already doing things for her, and also she used to get a bit depressed - when I'd go to school in the morning, she'd be in bed and I'd bring her up a cup of tea and an aspirin and all sort of [inaudible] whatever way it was, I don't know, but she could see it. Um, but my older sister wanted to go nursing and she fell in love instead, and she didn't. So I think maybe I was aware of that as well."

Jenny remembered taking care of other people as a child:

AS "Can you remember how long you'd wanted to be a nurse?"

JK " Oh, always."

AS "Since you could remember?"

JK "Yes, I looked after neighbours and people who had MS and I was the oldest of four and did a lot in looking after the other kids [SP] my brothers and sister and, um, yes, it was just part of my nature. "...

"I don't know about [SP] why [SP] why [SP] you know, what started me off being a nurse. I know I was always the one that held the handkerchief on the bleeding knee of a brother or sister or cousin, I know I was the one who my aunts and grandmothers, you know, would say 'Oh, Jenny, can you just do this while I...?' You know, 'He's bumped his head really badly and he needs this or that or the other. ' So, you know, I just seemed to be interested always in that sort of thing and I wasn't ever fazed by it... nothing sort of fazed me in it, whether it was with animals or with people, or whoever it was. So that was always very easy for me."

Other nurses linked their decision to do nursing with personal experience of illness. Alison had a disability which had meant that as a child she had spent a considerable amount of time in hospital:

"I was in hospital a lot as a child - in and out... And, as a child, always loved being in hospital, always loved being a patient. I was nursed a lot in ____, in those days - ____Hospital - and it was

like a second home to me, because I was in and out so often they really got to know me. And of course I loved it. And [inaudible] I always [SP] I remember, even as young as three, four, that sort of age, walking around with the doctors and feeling all important, and I was allowed to dress up to be a nurse, and be involved, you know, through play. And my yearning, if you like, to go into nursing, I think has stemmed from there - it's always been on the forefront of my mind that it was what I wanted to do."

Diane decided at a very young age that she wanted to be a nurse, and gained experience of caring both for family members and others:

"I remember when my grandmother had a heart attack at home and I went there and [SP] I didn't look after her but I remember going there and cooking for my grandfather, and I enjoyed that aspect. [SP] I've no idea how old I was."

AS " What was it you enjoyed about it?"

DL "I think [SP] I think it was the fact that I, er [SP] I think it was the fact that they [SP] they appreciated it and they said 'Oh, good. Oh, thank you!' Or ' Diane's done this' or it's like [SP] it's like somehow you have a role. It's like having a role, um, because when you're one of five and you're not the brightest of the bunch, er [laughs] or that's how you're seen, anyway - um, you [SP] you don't really have a place particularly..."

"... I worked in my school holidays in, um, what was the old peoples' home...right near where I lived, and I used to work there on my summer holidays, and I also worked in [a home for disabled children] nearby, where they would come for their summer holidays and I'd come and help..."

Barbara had lived in a nursing home as a child:

"[My mother] got a job working in a nursing home... so we moved and lived in the grounds of the nursing home. I was 15 then, and [SP] she made her way up to deputy matron before she retired, and my sister is now the matron of that nursing home... and that's sort of a big [SP] that nursing

home's always got, you know, a big part of my life, I guess. We've had wedding receptions there, and that sort of thing. And I think she was definitely my biggest influence. She [SP] although she's retired, she's still very much [SP] she's on the league of friends and very much into the caring professions [SP] she's the sort of person [SP] like, the neighbours all know she's a nurse, and they're, you know, 'Oh, can you come and help?' She's very much involved in that way, so..."

Twenty one percent of those who returned a completed checklist indicated that previous experience of health care work had strongly influenced them in their choice of nursing. Seven (24%) gave a high rating to "caring for someone as a child/young person" but none gave a high rating to "personal health problems" (see Appendix 8).

Parental and family influences

A large number of the nurses (23) said at interview that members of their family had influenced them in some way in their choice of career. Some parents encouraged their children to take up nursing. Susan's aunt was a nurse and she (together with Susan's mother) encouraged her in her choice:

"There was no...real reason for it. I couldn't think of what I wanted to do with my life and honestly it was that my aunt was a nurse and it sounded like it was all right... And there was no other deeper meaningful reason for it, other than [SP] I've tried to think if was there anything else [SP] reason for it, but I couldn't think of anything else to do with my career at that point so made the decision that my aunt was a nurse and it sounded all right."...

"... I remember talking about [what I was going to do] and I remember my mum and my aunt saying to me 'We think you'd make a really good nurse'.

AS "Ah! Did they say why they thought that?"

SC " No, I think that they thought I was probably fairly gentle and caring and so it was [SP] so I thought 'Well, I could give it a go'."

Angela grew up looking after her mother, who had been older than average when Angela was born:

"I grew up with my mother telling me 'Oh, you'd make a lovely nurse!' If I didn't have that once, I had it about 50 times. And I think I just fell into it."

Four respondents indicated that their parents had not pushed them in any particular direction concerning their choice of career. Alison's mother was a teacher but did not put any pressure on her daughter to follow her into the profession:

"... a lot of my qualities are in my mother, actually, thinking about it. I'm very much like my mother, and she is a good listener, a good communicator, very much into pastoral care within schools, which I feel myself to be quite good at."

AS "Did she ever try to encourage you towards teaching?"

AM "Mm [SP] yes and no. I mean, she would have loved one of her five children to have gone into teaching and none of us have. Um, no, she always wanted us just to be very happy in whatever we wanted to do and she would support that."

Five of the nurses indicated that their parents had not encouraged them to do nursing, had actively tried to dissuade them from doing it or had tried to persuade them to take up some other career. Grace became a cadet nurse when she was 17 but was not at all encouraged by her family:

"I remember when I started [as a cadet nurse] when I was 17, my mum said '<u>You</u> won't last in <u>nursing</u>!' she said. [Laughs]. And my brother said 'Oh, I'll give you six months.' And here I am, 30 plus years later."

AS "Do you know what they thought you would be better doing?"

GE "No, not really - no, they just didn't see it for me, cos I was a very quiet sort of 16 year old [SP] wouldn't say boo to a goose [SP] and they just couldn't see me in that situation. But I mean, I've grown up, so..."

Mark, whose aunt was a nurse, made a sudden decision to go into nursing and his father was not happy with his decision although he did not try to dissuade him:

AS "It's quite an unusual thing for a man to decide to do."

MS "Yes, well, my father was very unhappy."

AS "Was he?"

MS "Yes [SP] my aunt aside, he was very unhappy, and it was because of this [SP] reputation of attracting homosexual men [SP]. In fairness to him, he let me pursue it and carry on - by then, of course, he could see that I was fulfilled, and I was very happy doing it, so..."

Although Carol's original interest was in nursing, her headmaster had suggested she think about becoming a doctor, but her parents did not think this was a good idea:

"... the other thing about medicine was of course, I didn't get a lot of encouragement from my parents, although they would never have stopped me, because, um, in those days, they'd say, well it would be a waste of your career because you'll be wanting to get married and have babies, and you know, and with the best will in the world, they were trying to discourage me. So the attitudes to women working were so different in those days."

Catrina knew that her parents would support her in whatever she chose to do but was also aware that her father would have liked her to have become a doctor or a lawyer:

"... My dad's someone who's sort of 'Be a doctor, be a lawyer' that sort of person, but I brought him round to my [SP] see the thing [SP] if my dad had his way, I'd have done something more

academic in that way, but I think [SP] I'm [SP] I'm not someone [SP] I'm not influenced by money - I'm influenced by satisfaction in knowing it's a job well done and knowing I've made a difference. And my dad even still says to me 'Oh, you can still do your MBBS if you...' and I'm like 'Dad, but I'm not interested.'"

Felicity was encouraged to go into journalism by her grandfather, who had been a journalist himself:

" Um, my parents were very relaxed, so they were very happy with what I wanted to do, and I think they're very proud that I've gone into nursing, but there was never any sort of forcing me to do any sort of career. It was more my grandfather [who was a journalist] and sort of very much saying 'Have you written today?' He doesn't [SP] even now, he doesn't acknowledge that I'm a nurse."

Two respondents said their mothers had been nurses and seven referred to other members of their family who were or had been nurses. Christine's half-brother was a doctor and his wife, who was a nurse, was very supportive and encouraging when Christine expressed an interest in becoming a nurse:

"... a lot of people have been supportive. My sister-in-law, who is a nurse, was very supportive and I was able to get a lot of, um, information from her about what the training would be like and what nursing was about... she was delighted that I was going to be a [SP] you know, to do my training, and my mum as well. When I told her, she said 'More power to your elbow...'"

Hazel's maternal grandmother had wanted to do nursing but had not been able to:

AS " And was your mother pleased about [your decision to go into nursing]?

HV "She was, yes. She was pleased, yes, because it was a London hospital so I wasn't that far away at all. She knew that her mother - my grandmother - that I was very fond of, who actually was still alive until I was 17, so she knew that I wanted to do nursing, and it had always been her tremendous wish to do nursing, but her father wouldn't allow her to because in the early nineteen

hundreds, nursing was such a very, very hard, difficult career to go into. So she was not able to do that. She lived in Scotland and she had to help fund her family and so on, so that was not an option for her, but it definitely was for me [laughs]. And also, my sister went into nursing later as well..."

Three respondents said that their father or another relative was or had been a doctor (including two of the men interviewed). Gordon, who started nurse training at 21 after a series of jobs in a hospital setting, said that he came from a "medical family":

"Well, my dad's a doctor - he's a surgeon. I come from quite a medical family, and my brother was in hospital administration as well, so it was [SP]. My other brother's a doctor as well - he's a GP - so [SP] it's quite a medical family, yes."...

AS "In some cases, people might say that having a father who was a GP would put them off working in the health service..."

GW "It can do. It depends on [SP] because my dad loved his work, and he was very good with his patients, you know, he was the old type of GP, you know, where he would spend time with people and visit out of hours and become more of a friend of the family."

Other people's influence

Fourteen respondents referred to people other than members of their family or teachers/careers advisers who influenced them in their choice of nursing by acting as a role model or in some other way. For eight respondents, knowing a nurse or having a nurse 'role model' was reported as having been effective in moving them towards nursing and "knowing a nurse" was highly rated at an influencing factor by 7 (24%) of those who returned a completed checklist (See Appendix 8). Female nurses interviewed always referred to a female nurse, nurses or role model. Marion worked for many years in the catering trade but was eventually made redundant and took a job as a nursing auxiliary at a hospice, which inspired her to do her nurse training:

"So I started my, er, auxiliary nurse, and I think I was quite nervous to start with - perhaps needed a lot of guidance. But I eventually began to enjoy it, and I think I was really inspired by the nursing team and I think, in part, or to a greater degree, I think, the nursing team at (hospice) has a lot to answer for my desire to know more and then to go on and train."

Diane had been influenced by a next-door neighbour:

"We [SP] er [SP] when we lived in ____there was a next-door neighbour, Mrs Brown, who was a nurse, and I loved Mrs Brown because she gave me a lot of attention. I used to go and stay with her - and I remember [SP] gosh, I mean, this is a long time ago [SP] I remember looking through some of her books and thinking she was pretty something - she must be something special, and she would tell me stories of the hospital and things, and I think she [SP] I think she did have an influence on me."

Mark had been influenced to become a nurse by a beloved aunt:

AS "And what were the influences...?"

MS "My aunt."

AS "Oh, OK, and was she a nurse?"

MS " Yes, yes."

AS "And had she tried... was it just by being an example, or had she tried to persuade you?"

MS "No, just a person I loved."

AS "And what did she do - what specialty was she in?"

MS "Sorry, I get a bit emotional about her because she's very ill. She was a matron. She was always [SP] she was a night sister, and then a matron of a hospice in ____called ____and one was always conscious of [SP] of her and of her being what she was. And [SP] this is on my father's side, and his mother always spent a lot of time with her [SP] was always talking about her and was always praising her, cos she [SP] she'd done well [SP] she was the one with a career and left the family farm... she was somebody who had letters after her name you know [SP] I remember that being said, and it was sort of something that you looked up to. But, I mean, I was at a bit of a loss as to what to do, frankly. [SP] I think [SP] I think my poor father was tearing his hair out as to what I was going to do, cos I didn't know."

Matthew, said that his first encounter with a male nurse while working in a health care context while studying for his merchant navy exams had made him aware that nursing might be a career worth considering:

"It was that through holiday jobs I got work in a health care context. I worked in both a hospital and a home for invalid servicemen - Oh yes, it was an RAF home. And that was where I met my first male nurses to know that it was a professional group, because nobody talked to us about that at school..."

Having a friend or friends who became nurses was mentioned (sometimes as an influencing factor but sometimes as not specifically influencing) by five nurses. Felicity, who first worked in a clerical job after leaving school with A-levels, indicated that a friend's decision to do nursing had triggered her own awareness of what she wanted to do:

""Well, I wasn't sure [what to do]. Number one, I didn't want to go to university and I think to follow that course in journalism, you'd have to take on a degree and I didn't particularly - at that time - want to do that, and so I just wanted to find a stopgap just so I could make my mind up what I wanted to do, and that's when I went into doing the clerical work, and while I was doing the clerical work, one of my friends applied for nursing and I suddenly thought 'Oh, yes!' You know, 'I really wanted to do that!'

Jenny, who did a pre-nursing course before leaving school and starting her nurse training, had decided by the age of 15 that she wanted to become a nurse and was not tempted to change her ideas when a job with the BBC was suggested by a member of the Corporation's staff:

"... my father was in the forces, so I moved and I went to 12 schools and I had a year out of school when my mother taught me, so [SP] I was educated to O-level and I then wanted to [SP] all I wanted to do was be a nurse. I was sort of [SP] I did quite a bit of public speaking and won prizes at that and somebody from the BBC wanted to know whether I'd be interested in a job in the BBC, and I said 'Oh no, I'm going to be a nurse.' So I was really focused that I was going to do that [SP]. That's all I ever wanted to do."

Patricia, who had wanted to be a nurse at the age of 16 was dissuaded by her boyfriend and did not take up nursing until later in her life:

"You know, there wasn't a lot of advice in those days, and there was a lot of people who were going into nursing - a lot of my friends went into nursing. Um, and it was just something I thought about, but my [SP] again, my boyfriend [ex-husband] didn't want me to do it, cos he said 'Well, you'll work shifts and I won't see you.' So [SP] gullible 16-year-old, I just said ' OK, then, I'll go and do office work.' So I [SP] I took a secretarial job instead."

AS "So when you were doing that, where was the idea of nursing? Was it still at the back of your mind?"

PR "Well, I think [SP] I think I kind of buried that, quite quickly, just because it was kind of dismissed as something I couldn't do. Um [SP] yes, I don't [SP] I can honestly say I don't [SP] it didn't resurrect itself until later."

Gender role assumptions

Although five of my 30 respondents were male, only around ten percent of nurses in the UK are men (Department of Health 2007).

Christine neatly illustrated societal gender-role assumptions in her reflections on her own career expectations as a child:

"... I don't know if this is helpful or not, but when I was very young I used to assume that little girls grew up to be nurses and the boys grew up to be doctors. And I think [SP] my half brother was [SP] he was much older and was just going off to university to do his medical training, so that must have had something to do with it. Um, you know, 'he's a boy - he goes off to be a doctor."

The fact that very few men choose to become nurses was referred to by all the male respondents (though in some cases this topic was specifically raised by me in the interview). Matthew felt as he imagined it must feel to be a member of an ethnic minority group:

"... we're still only 10% - I mean, 10%! It's like being an ethnic minority almost;10% of a professional group is too small."

Graham reported that his friends had been highly amused when he had decided to begin his nurse training:

"... a lot of my friends thought it was, you know, sort of a hilarious choice and I think it really sort of came out of the blue for a lot of people - they didn't really expect me to do something like this."

AS "What do you think they might have expected you to do?"

GN "Um, I don't know, I suppose [SP] apart from the usual, really. I mean, most my friends work in, you know, sort of office-based jobs [inaudible] accountants."

Three male nurses referred to societal assumptions that males working as nurses "must be gay." Jonathan had encountered these assumptions in his work:

"... I've come across, um, some people whose attitude is basically 'Anyone in nursing or in the medical profession who's a man is gay. End of story. Because otherwise, a woman would be doing it."

Jonathan recalled an instance in which a male relative of a patient had assumed that, because he was a man, he could not be a nurse:

"... during my training, one telling thing, I think, was that I was with a mother and child with the [SP] um, she did have a baby, I can't remember the name of the person who did it now, but I turned up and I said 'I'm Jonathan, I'm a nurse.' And he went 'No you're not, you're a man.' And I just thought [SP] you know, this is only seven [SP] what, eight years ago, but I mean [SP] so you just think there's still a lot of, um [SP] not bigotry [SP] there's a lot of - although there is - there's a lot of people's expectations that 'nurses are women, doctors are male, and the two can't cross' but I think, even though that's still being challenged and [SP] yes, I do think, you know that the two cut across and I've never really cared whether people think I'm gay, straight or [SP] stupid [SP] so [SP] I'm quite selfish like that. [Laughs]"

Mark said that he was not gay, but had encountered societal assumptions that men in nursing must be " either gay or sex mad":

"... there are still quite a number of lesbians in palliative care. I'm thinking now [SP] I know quite a few...

AS "And does that apply to gay men as well, because there's always been a sort of...?"

MS "No, no. No, there's never been, no, exactly. Never [SP] never been gay men in palliative care. You know [SP] and [SP] and I'm not gay...

AS " But the tradition of [SP] I mean the public image of the male nurse is "Oh, he must be gay!" You know, I haven't actually met anyone who's used that phrase..."

MS "Oh, they used to, I'm sure."

AS "But that is, I think [SP] I mean other men I've spoken to have told me that this has been a problem for them in their lives. Although they're not gay, people have assumed that they are, because they're nurses and they're men, and therefore they're gay."

MS "Yes, yes. Well, it used to be said when I was training that you were either gay or sex mad.

AS "[Laughs] Yes, I can see the logic in that.

MS "That's what they used to say. 'Oh, if he's not gay, he must be [SP] completely rampant [?] heterosexual. I [SP] I know I've never been gay, um, naturally enough, because I'm in a profession where there were a lot of gays... but they've never [SP] it's never been a specialty [palliative care] that's attracted male nurses, actually."

Matthew had encountered various problems in his younger days as a result of assumptions either that nursing was not an "appropriate" career for a man or that, as a male working as a nurse, he must be gay:

AS "What about the image? Because I mean, it is such a feminine image isn't it, the nurse?"

MS "Well, this is a problem. I mean I've had a lot of social problems in my earlier youth days, premarital days. You'd go to the parties and things and the girls would all assume you were homosexual for a start, which was a real killer when you were trying to get someone on a date, you know [mutual laughter] which - when I think of actually the people I've worked with, most of them are married men. It is a real [SP] male ballet dancers get the same problem... if they're not gay. That's not to say that there might not be an above average proportion of gay men in nursing - I don't actually know. I've never seen any figures - no one would publish it. Because it's the sort of job they may be attracted to. So [SP] well, there were one or two occasions - it took me some years to work out what on earth people [SP] because I didn't hold this in my mind a lot, and you know, there were people who said [SP] there was a chap who said to me in a club I'd joined 'We

don't welcome your sort here.' And I'm absolutely certain now that what he must have meant was that I was gay...He didn't even ask if I was, but it took me years to realise the reason they wanted me to leave. I tried to think: 'Have I said something? Is it the way I look or' [SP]? All these things. It's very unpleasant, you know. People don't realise how unpleasant this sort of thing is."

AS "Is that [SP] do you still find that an issue?"

MB "Well not really, no. I mean with age has come - you know, when you're a family man with kids and so on [SP] I haven't heard anything like it for years."

Matthew observed that while men represented a very small minority in nursing, they were overrepresented in the higher ranks of the profession and he attributed this to the fact that while a lot of women "want[ed]" to remain as nurses (rather than go into management), there was - or had been - a pressure on "family" men to take more highly-paid jobs:

"... you end up with this 10% - there was one figure I saw where it was something like 50% of the managers were men, which is way out of proportion to the numbers in the profession as a whole. But you see, there are lots of female colleagues I've met who very specifically want to stay as clinical nurses, which means they <u>have</u> to stay in the staff nurse or sister grade. And again, there was certainly when I was younger, this pressure on men to earn more to keep a family - if you were going to be a family man - so you couldn't <u>afford</u> to stay as a staff nurse to be a family man."

Schooling

Almost all the nurses (27) referred to some aspect of their schooling which might have related to their career patterns, including choice of A-level subjects, encouragement and discouragement by teachers and careers advisers regarding specific career choices and school-arranged work experience. Four respondents referred spontaneously to subjects they had enjoyed at school. Catrina's main problem in choosing subjects was that she "liked everything" on offer at her school:

"... I like science a lot [SP] like the biology and chemistry - I'm not really into physics."...

"... when I went to see the careers adviser at university [sic] I [SP] I said to her 'I like to work with people.' She was like 'What are your interests?' But then also, I'm quite technical as well. I really like computers, cos I've always been brought up round computers... so that's also another aspect that I like..."

Three respondents said that they had chosen their A-level subjects with a nursing career in mind. Steffie, who did her nurse training in Australia, felt fortunate in having decided on nursing at a young enough age to enable her to choose relevant subjects at advanced level:

AS "... when was it you actually thought of working with children as a nurse? When did that idea come along?"

SZ "Probably when I was [SP] probably when I was deciding what courses to take in [SP] like my A-levels [SP] what course to take then. We sort of had to pick what we wanted to become and then from that you [SP] you worked out what subjects you needed to take to achieve the right TER entrance and have enough knowledge before you went on to university. For me, I was very lucky, because I knew I wanted to be a nurse - I had no problem at all. My sister on the other hand she didn't know what she wanted to do [SP] to achieve, she didn't know what subjects to take, and so she ended up not doing her HSC. She couldn't see any point to it, so she got a full-time job and started out that way."

Amy had a sociology degree in mind so had chosen suitable A-levels for that and only later began a nursing course:

AS "Did you do A-levels with a view to going into nursing?"

AC "No."

AS "So what did you do?"

AC "I did A-levels with a view to go and doing a sociology degree."

AS "Oh, right. And did you actually go on and do that?"

AC "No, I actually went for interviews at various places, but decided that I wasn't too certain about it, so I was going to take some time out before I decided and [SP] so that was what I did."

Six respondents remembered having chosen their A-levels with no particular career in mind. At the time he chose his A-level subjects, Gordon did not know what sort of work he wanted to do:

AS "And when you did the A-levels, was there any thought of [SP] did you choose the A-levels in terms of what you wanted to do?"

GW " I chose but, no, not really, but I didn't really know what I wanted to do then, so [SP] I can't remember what I did. I think I did maths, economics and geography, I think, so..."

Only one respondent said she had been encouraged in her choice of nursing by a teacher or careers adviser. Mary, who decided on nursing at the age of six or seven, was encouraged by the headmistress of her secondary school:

AS "And when you were at school [SP] were there any sort of influences there that encouraged you to do nursing?"

MT "The headmistress, certainly. Funnily enough, this very academic strict Scottish headmistress but had a great sense of social justice [SP] you know, that ethos [SP] and so very much encouraged a half dozen of us [SP] I'd say that most of the teachers were more interested in the academic girls but, um, that didn't matter, because I was quite gifted at acting and drama [SP] you know, I had other talents that kept me going, um, so I was really happy at school. I don't remember not [SP] minding that I was particularly academic [sic]."

Three nurses said they had been discouraged from nursing by teachers or careers advisers. Diane was somewhat discouraged by a biology teacher who had been a nurse:

"I remember saying to my mother 'I think I'll be a nurse' and, um, we were in England, so I was older than nine, so I was probably about 10 or 11. And I remember saying it to one of the teachers at school who I knew had been a nurse - a biology teacher - and she said, um, ' It's very hard work.' You know, 'You want to think about it very carefully.' And thinking 'Oh dear, she doesn't think I'm up to it.'"

Marina, who was good at English at school, was told by a business studies teacher that she would be "pretty wasted" as a nurse:

"... I did well in my GCSEs and my A-levels [SP] what they say better than doing a nurse [?] - they didn't want me to be a nurse in ____ - they wanted me to go across the way and do doctor or something, but nothing would change my mind from being a nurse."...

"... cos I was very good at English, a lot of my teachers wanted me to go and do like English degrees and stuff, um, then business studies was a near one, cos there's a lot of essay writing in that I turned out to be OK at, so he thought I'd be good sort of doing a management thing - he thought I'd be pretty wasted as a nurse."

AS "Who thought that?"

MO "The business studies teacher."

AS "What did he think you should do?"

MO "He thought I should have gone into, like, running my own business or designing something, or inventing something and marketing it myself, cos we had [SP] like we had loads of little projects like that, and he sort of thought I was a natural. [SP] It was like 'What do you want to be a nurse for?' He was [?] very money orientated. I said 'Yes, but you're a teacher.' [Laughs] Same as being a

nurse really - you're not in it for the money - you're in it for what you can get out of it, really... so [SP] I didn't feel very encouraged to be a nurse, really, from school..."

Five respondents said that teachers or careers advisers has suggested careers other than nursing. Marina was advised to study medicine (see above) and Carol's primary school teacher also suggested that she study medicine:

"And from then on, that's what I wanted to be - a doctor. And then, by the time... I got to the sort of A-level stage, I knew no [inaudible] I haven't [SP] well, I haven't got the temperament. [SP] I probably could have struggled and done it - I probably could have done it, but I knew it would be a pressure [?] - it would always be a struggle."

AS "So you came back to it?"

CE "So I came back to nursing."

Seventeen of the 30 respondents referred to careers advice offered by their school (either by teachers or careers advisers). Of these, three said that they had not made much use of the advice on offer. Gordon, whose father was a doctor and who started his nurse training at the age of 21, said he had not taken much notice of the advice offered at school:

AS "Did you have any careers advice or anything when you were at school?"

GW "There was, but I didn't really sort of take much notice of it, really, I think, looking back. I mean when you look back [SP] if you knew what you know now [SP] you realise you'd have taken more notice of things, you know, when you're starting out on life. I don't think it would have been possible. [SP] I don't think I would have changed anything now anyway, you know, because [SP] enjoying the work, but I'd love to have been a pilot."

AS "Oh, really? How old were you when that idea came along?"

GW "Well, it's always been there. I've always loved flying and that, and particularly more now [SP] but it's obviously too late now..."

By the time she was offered careers advice, Stella had already decided on a nursing career:

"... I can remember having [SP] interviews at school with the teachers about [SP] you know, what I was looking at and what I was wanting to do, but I don't think anyone came from outside about it, no. But I think I was fairly adamant about what I wanted to do."

Six nurses indicated that the careers advice they had been offered was poor or limited and four said they had not been offered any careers advice while at school. Elaine had not thought much of the advice she received:

"... I was just very unhappy [at school] - very unhappy. I didn't, um [SP] I didn't thrive in that atmosphere at all, but I think through my teenage years I was quite a troubled sort of person anyway [SP] having to deal with stuff going on at home that was a bit [SP] you know [SP] and I was expelled from one school, and then when I left school, my [SP] it was in the days when they had, um, careers advice sort of teachers, who had taught you through the year and were sort of [SP] were supposed to guide you into what they thought you'd be suitable for and just have a sort of counselling chat with you, as it were, and I was in there for five minutes. She literally [SP] she sort of virtually said I'd be working in a factory and get married, have lots of babies, and that would be my life."

AS "Did she ask you what <u>you</u> wanted to do?"

EA "No, not at any stage she didn't ask me."

AS "How did you react when she said that?"

EA "Well I didn't really. I think [SP] I know I came out of there thinking 'Stupid old bitch, what does she know about me? I'll show her!' "

AS " And had you got any ideas at that age about what you wanted to do?"

EA " Yes, oh, I knew. I knew I wanted to be a nurse."

Mary decided on nursing at the age of six or seven and was encouraged by her headmistress but said there had been no formal careers advice at her school:

AS "Did you have careers advice in those days?"

MT "No! [Laughs] Nothing like that! You must be joking! [Shared laughter] did you?"

Steffie felt that careers advice given at 16 was not particularly useful:

"To imagine at 16! At 16, to know exactly what you want to do with the rest of your life!"

Two respondents referred to having had relevant work experience while at school. Christine had worked in a hospital and Marina in a pathology laboratory:

"[The school] didn't seem to be doing much, so I got [SP] 'If you can't do it, I'll do it myself'. So I got, um, a job [SP] like a two-week work placement when I was sixteen... I got a job in the path lab for two weeks. It wasn't actual nursing or anything like that, but I sort of bit their hand off, because that was the only thing I could get and that was at the ____, ... there was a mortuary there, so I got involved in a lot of the post-mortems and stuff, so it was very good in terms of what I wanted to do - it wasn't a waste of time at all. Like when I walked in, I thought 'I'm going to be looking at bits of mould all day, and stuff' but when I sort of found out that it was there, I said 'Can I go over there and do that?' sort of thing. So they said yes, no problem, so [SP] it was [SP] it was a good experience, actually and quite good for the nature of the job I'm doing now [SP] but there was no sort of [SP] I didn't know them from Adam - they were just there. It was like sort of a person on the table - there was no relationship there, so it was very different to this in a way, but also quite [SP]

quite good for the sort of [SP] not to sort of harden to it, but to realise that everyone is just a person at the end of the day and you're dead or alive... just to see death as death and that was it..."

(Marina)

Janet had asked to be placed in a hospital for her work experience but had been given factory work instead:

"I must've wanted to be a nurse for a long time, actually. I think I did, actually. [SP] I haven't thought a lot about it, but when I was quite young I did, and I asked to go to, um, a hospital to have work experience and they sent me to a factory."

AS "Oh, right, OK!"

JF "So I didn't get encouraged..."

AS "How old were you then?"

JF " Fourteen."

AS "And did you enjoy the factory?"

JF "No. Not really. And they gave me some money - I think they felt sorry for me that I'd been sent there."

Images of nursing

Eleven respondents referred to the images they had held of nursing prior to starting their nurse training. Two of these described highly personalised images. Diane said that, while she had had little idea what nursing involved, she had held a very positive idea of how it would feel to be a nurse:

"I mean, certainly, when I was 18 I hadn't [SP] or younger than that, I hadn't a clue what nursing was about - I just wanted to be approved of by my parents - that's what it was all about. And I imagined myself on a bicycle as a midwife, and people calling me up and rushing to their aid and making [SP] saving the day, and people would say 'Good old Diane!' which is what my parents say now."

Angela's strong negative image of one particular nurse did not put her off becoming a nurse herself:

"I think I went to the careers guidance teacher with the suggestion myself [of becoming a nurse]. And I certainly didn't follow the village nurse, cos I was petrified of her. She was a huge big woman who stuck needles in my bottom, as far as I was concerned, and she hurt me every time..."

Three respondents admitted that they had known very little about nursing prior to entry to nurse training. Stella went into her nurse training straight from school:

AS "And would you say, when you were thinking about doing nursing, were there any practical issues that you had in mind, like wanting to get a job that would give you flexibility or opportunity to travel or knowing that you'd always have a job?"

SB "... I don't think I did. I mean, I was 18 and didn't have a clue, basically... I think I just went into nursing. [SP] I don't think I really thought about that."

Two of the nurses had initially assumed that nursing would be too difficult or complicated for them. Working in a nursing home led Christine to rethink this assumption:

"I loved English and I wanted to do an English degree. Went off and did it and then one summer, at the end of my second year, I got a, um, a summer job in a nursing home as a care assistant. And when I discovered that it was lovely to [SP] um, to interact with the [SP] the residents, and the

[SP] that was very nice, and that actually the job wasn't that complicated and maybe I could manage nursing after all."

AS "Had that previously been a problem?"

CG "I think I'd [SP] yes, I mean [SP] I thought probably [SP] the whole world of nursing was such a mystery. You'd have to know so much in order to do it. But of course, that's what you get the training for!"

Kerry's mother had insisted that she learn secretarial skills before leaving school because she did not want her "working in Woolworth's." Nursing was not something Kerry considered at that stage of her life, partly because it seemed beyond her reach:

"... when I was at school my mother used to say to me 'When you leave school, I want you to learn [SP] before you leave school, you're going to learn secretarial work so you can be a typist, because I don't want you working in Woolworth's.' So there was no, um [SP] thoughts of being a nurse, cos I was always told it was too high, anyway, you know, to even think about, so I was just being driven by what I was being told by my mother. But then, um, when I did leave school I did go into secretarial work and I ended up in police stations [SP] more legal [SP] and I remember the one day I thought 'No, this isn't for me.'" ...

AS "Was there anything at all [at school] that suggested nursing?"

KD "Well... cos I was probably, you know, working class, you didn't think about it. And they never actually told us there was an SEN[10] or an SRN[11] [SP] it was just nursing [SP] you know, you needed 0 levels, and I knew I never had O levels so I didn't even go down that road."

Four of the nurses referred to positive images they had held of nursing prior to commencing training. Jonathan had thought working as a nurse would be "worthwhile":

[10] State Enrolled Nurse
[11] State Registered Nurse

AS "... whether there were any people who influenced you in your choice of nursing or palliative care."

JP "... only my Christianity, I think. And I think I need a [SP] quality in me to get out there and do something... that was worthwhile. But nobody in particular."

Christine had initially been put off nursing by her school work experience in a hospital:

AS "What sort of things were putting you off?"

CG "I think actually that, um, a lot of the time I was with nurses who weren't doing hands [SP] weren't doing ward nursing. I spent a whole - to be honest, very boring - afternoon with a lady who did contact lenses. And she was, you know, a trained nurse, and um, the only things I remember about the ward really was weighing somebody, um, and I had that fascinating day in theatre, um, but never particularly liked the whole atmosphere of the operating theatre - wouldn't want to work there, so [SP]"

AS "What was it about it?"

CG " Um [SP] I think the fact that the patient's asleep [laughs] and that, you know, yes, you're helping them and everything, but not in a [SP] not in an interactive way."

Books and television programmes had provided positive images of nursing for three respondents. For Alice, reading a novel as a teenager had "sowed a seed" which led her to register for a pre-nursing course at college:

"... I was going to be a hairdresser, cos that was quite an easy thing to do [laughs] but then I read a book - one of those silly sort of soppy teenage things about Nurse Somebody, and I can't even remember what, and um, I mean obviously it was all a romantic notion about being a nurse but I thought 'Oh, I'd quite like to do that' and it just sowed a seed and I just decided."...

AS "So how old were you when you read that? Can you remember?"

AD "Mid-teens? Still at school... yes, still at school, because, um, yes, I wouldn't have done my O-levels."

For Marina, television programmes in which nurses were portrayed as "with the patients" enhanced her image of nursing as "hands-on" work:

"... it's [SP] it's just the sort of hands-on nature with it, really, that sort of made me want to go in and do it. And I keep going on about the telly and stuff, but you'd just sort of see [SP] the nurses with the patients and [SP] then my cousin as well[12] [SP] like my auntie never wanted to see the doctor because they didn't see them all the time - it was sort of the nurse that was there..."

Steffie recalled how, as a child, she was allowed by her parents to watch one particular programme on television:

AS "Do you remember why [SP] where the idea came from...?

SZ "No, I don't. We watched a lot of [SP] er [SP] possibly growing up, *Country Practice* is a television programme - nurses and doctors in the country in Australia...There's lots of morals and things in there that we [SP] our parents let us watch that show - it was one of the ones we <u>were</u> allowed to watch."

Pragmatic factors

Very few respondents referred at interview to practical reasons for going into nursing, such as wanting a job that would allow them to travel or provide them with a reliable supply of employment opportunities. Graham had met nurses while working abroad after leaving school, and had liked the idea of a job which would allow him to travel and work abroad:

[12] Her cousin lost a leg in an accident and she visited him in hospital

"... When I was travelling, I met lots of nurses who worked [SP] sort of part of the year and spent the rest of their time travelling, which was a lifestyle that quite appealed to me at the time..."

Hazel's father had died when she was 14, and when considering whether to go to university or to do nursing, Hazel bore her mother's financial situation in mind:

"... I felt that with my mother having been left as a widow, that to do nursing was the better career for me because I was going to be paid as a nurse, whereas if you go to university, you would have needed to have more money available...."...

"... the training was paid for, so that was, you know, very [SP] one good reason for doing that..."

Felicity referred to a recent discussion she had had with a nursing lecturer, who had suggested that people were now going into nursing not "to care" but simply to get a job, and felt that the training currently provided failed to equip nurses with the necessary skills and understanding necessary for hospice work:

"I think it's a different quality of people who are coming through, whereas I think before there was always very dedicated people who went into nursing, because it wasn't for the money or anything like that. It was actually, you know, to look after people. I don't think that is there any more. I think they're coming in because they've got a job, and they can carry this qualification wherever they want to go, and they're guaranteed to get a job somewhere."

In response to the checklist, none of the nurses rated "financial reward" as having had a strong influence on their choice of nursing, but six (21% of those who returned a completed checklist) gave a high rating to "job security" and three (ten percent) to "convenient locations/hours". (See Appendix 8).

Lack of planning and 'chance'

We have already seen that, with one exception, none of the nurses had planned to go into hospice work when they applied to do nurse training. We have also seen that a significant number of them

had not had a clear idea at school of the sort of career they would like to follow. A small number of respondents indicated specifically that there was an element of 'accident' or 'chance' in the fact that they trained as nurses. Jonathan, who had worked as a painter/decorator, as a fireman and then gone to theological college, referred to the opportunity to do nurse training as having "dropped into [his] lap":

"I didn't like the idea of being a nurse, because it was obviously far too difficult, but I'd been doing training as a health care assistant, um, with an agency. Um, but then, ironically, it was one of those situations where, um, the opportunity dropped into my lap to go to ____University for an interview and within three hours, subject to references, I'd been accepted onto a diploma course to do nursing."

AS "How did it drop into your lap? [Laughs]"

JP "Literally, I was, you know, just going through the newspaper. Thought 'Oh, that looks interesting - they're looking for nurses. I'll go along and see what they're doing.' It was an open day. Popped along to ____, um, they offered the interview, and as I said, three hours later, I'd been accepted. So I was [SP] you know, got on, without even thinking about it."

Patricia, who went into nursing as a mature student via clerical work in a hospital and working in general practice management, saw her move into working in general practice as having been "accidental":

"I can't say that I went into the NHS on the clerical side with a view to doing my training. [SP] I can't say that was on my [SP] on my mind at all. At the time it was just a job that fitted in with nursery hours that meant I could get out a little bit, spend some time away from being with a two-year-old all day and use my brain a bit. And then I took an accidental step, if you like, into working in general practice. I realised it was hard to progress within the hospital, so I went for a job as an administrator for a doctor's practice out in a village and kind of stumbled into this growing land of general practice."

Patricia eventually left general practice and did temporary work for a while before starting her nurse training:

"I applied to ____[SP] I applied to [SP] let me think [SP] I'm trying to think how I [SP] because again, it was one of those accidental things. How did I do it? There was a job in the paper advertising for an outpatients' assistant working in the private wing at ___Hospital..."

Having worked in this post and also as a health care assistant, Patricia made the decision to commence her nurse training.

Sandra, who had wanted to go into graphic design while at school but had been put off by her work experience, indicated that her decision to go into nursing had not been carefully planned:

AS "So when did the nursing idea come in?"

SI "When I was 21, not for any specific reason that I could think of. I think, um, in a cynical way I probably thought that at 21 I should perhaps be looking at [SP] not a job, more a career, um, and I always knew that I didn't want to work in an office and sit down - I always knew that I'd be awful behind a desk, and I think it's nothing [SP] nothing deeper than that. It's probably not very helpful for you, but [inaudible] [laughs] no deeper than that."

Chapter summary

The nurses' accounts of the factors which influenced them to become nurses reflect the results of previous research, suggesting that a wide range of personal and social factors are identified by individuals as influential in choice of nursing as a career, with the desire to be 'helpful' to others accorded particular prominence.

In making sense of their life journeys, the nurses accorded special importance to the influence of other people - particularly family members, role models and teachers - in moving them towards or away from nursing as a career. Having begun to develop their occupational ideals and values,

some of the nurses had actively resisted attempts to persuade them to pursue other careers (that is, had defended and affirmed their being-towards-care) and for men, it had been necessary to defend their being-towards-care against societal gender role assumptions.

In the next chapter**,** I examine the nurses' narratives of becoming hospice nurses.

Chapter 8: Acquiring a sense of identity

In Chapters 6 and 7, I examined how the nurses reflected on the ways in which they came to make the decision to become a nurse. In this chapter, I look at how they talked about their experiences during nurse training and I attempt to make links between these and other experiences and their acquisition of a hospice nurse identity.

General training experiences

Fourteen of the nurses recalled general aspects of their training they had enjoyed.

Jonathan, who had gained experience in various occupations before training to become a nurse, recalled having enjoyed the practical parts of his course more than the academic aspects:

"I enjoyed lots of the training. I didn't enjoy the academic stuff - even with a degree in theology I'm not actually academic. Um, I don't [SP] I'm [SP] I'm much more practical, you know, I like doing things with my hands, I like helping people and stuff like that."

Kerry, who began her training in the late 1970s, remembered having found her nursing course "easy" and particularly recalled the way in which nurse tutors would work with students on the wards:

"Yes, it was easy. It was so different in those days, because it was practical training, whereby you learnt in the classroom, so you had, say, the first six weeks in the classroom, learning about how to sit a patient up - all the basic stuff. Then you went on the ward for eight weeks. Then the teacher used to come into the classroom [SP] um, onto the wards [SP] 'How are you working?' They used to really teach you properly. And they were in uniform as well. And then they'd have you back in the school, and it was really marvellous..."

Elaine recalled that, as a student nurse, she had sometimes been left in charge of a ward, and that she had seen this in a positive, rather than a negative way:

"Well [SP] at the time, I think it was an honour. You know, it was quite [SP] it wasn't scary. I didn't find it scary. I found it quite [SP] I don't know, you just kind of did it - you just did it, and got on with it."

Graham, now a nurse manager, said he had very much enjoyed spending time on the wards talking to patients - a preference which had not always gone down too well with members of the nursing staff:

"... I used to get in [SP] not in trouble, that's the wrong [SP] but you know, people didn't value it [SP] didn't value the fact that I would sort of sit and spend time with [people who were dying]. They'd sort of say 'Oh!' You know, 'We've got other more important things to do.' And I used to [SP] you know, I didn't really see that at all [SP] you know, I found that was the most rewarding thing in my training... "

Eleven of the nurses referred to general aspects of their training they had not particularly enjoyed.

Sandra, who had studied nursing at university, recalled having felt quite frustrated during her training by restrictions placed on what student nurses could do on the wards. She had found her training quite stressful and had opted for the diploma, rather than the degree:

"... I was always quite cynical at university, thinking that [SP] you're quite restricted and although you're a student nurse and you're learning, when you're out on the wards there's not a lot you're allowed to do and I always felt like I was caught in this net, where I didn't have the experience to be allowed to do things, but how could I get the experience if I'm not allowed to do them? So therefore... my academic stuff became a bit less important to me. It came as a means to an end, if you like..."

Jonathan remembered having found himself treated "like a twelve-year-old" when he did his training:

"I was quite mature and having obviously been through life and the RAF and theological college, to come to this one where they treat you like kids [inaudible]. You treat me like a twelve-year-old, I'll start acting like a twelve-year-old, and I was told that I was immature [inaudible] um, so that was kind of fun..."

Catrina, working in a hospice in her first nursing job, had several negative memories of her training, including patient care which failed to match her ideals:

"... my first ever placement I had on the ward, I hated it. I absolutely hated it. I thought 'My God! What on earth have I let myself in for?' And I really wanted to leave the nursing course straight away, and it was my mum who said to me 'Just stay it out. Do the three years. If you really hate it that much, then leave afterwards and do something else.' "

AS "What was the placement?"

CA "Oh, it was the most atrocious [inaudible] It was an MRSA-positive ward and I hadn't even been taught infection control at university at that time. So my very first experience of nursing was an enema and my second experience of nursing was a patient who had a tracheostomy and they had phlegm coming out of that - this was my second experience, and just [SP] the nurses that I worked with in my training have been atrocious! Like really old school [SP] not even caring about patients [SP] very blasé about the whole job, and just really unkind and rude. That's what I found really off-putting."

Patricia, who did her nurse training as a mature student, had not particularly enjoyed some of the more basic nursing tasks she had been expected to perform while in training, but had successfully used her experience to move herself on to other, more complex tasks:

"... my first placement was care of the elderly, and I wasn't very happy at first, because I'd looked after lots of older people as a health care assistant, but looking back, the transition that you make as a student through the first, second and third years is very interesting, and I think my first placement was [SP] what I call [Laughs] I call it 'Commode City' because it was a baptism by fire. I

think, especially new students [SP] 'Right, put them in, see how they go.' And basically, you are just, you know, doing the commode runs all day, and because I'd already done that and knew how to do that I was kind of [SP] obviously [SP] and I mean, again, because I'm older I wasn't frightened to go to the sister and say, you know, 'Can I do something more than this? I actually want to learn more. You know, you can sign me off. You know I can do this - what else can I do?' And eventually, they realised that I was a keen worker and I was enthusiastic, so my reward, if you like, was [SP] was then that they would let me know if there was certain procedures and they'd say [?] 'Oh, Patricia can sit in' which often, as a first year, you're not allowed to, but I did very much push myself forward and make the placements my own and took from them what I could."

Marina, who had gone straight from school into nurse training and straight from nurse training into a hospice job, had not enjoyed the responsibility placed on her as a student and, like Catrina, had found that the realities of nursing did not match her ideals:

"... even as a student [on an acute cardiac ward] I was one of numbers when I should've been supernumerary. I was in my final placement, so like, I should've been ready, which I felt I was, but it's not a fair situation to be in, either, and it's not the way you want nursing to be, really, but it is the reality of nursing as well - not enough time, not enough stock, searching for hours for hoists, whereas here you don't have to do that."

Nursing specialties: likes and dislikes in training

Twelve of the hospice nurses remembered having specific likes and dislikes among the nursing specialties in which they had worked during their years in training.

Marina, who had assumed she would enjoy the activity of Accident and Emergency, had found herself enjoying a neurology surgical placement in which she was able to build up a good relationship with one particular patient which profoundly affected her career path:

"Um, all my [SP] none of my nursing placements really had anything to do with palliative care as such, so there's [SP] I had a neurology surgical placement, and there was a lot of people with

cancer that came through, such as bladder and bowel cancers, and things like that, and I always thought I'd be quite an A & E orientated girl... I thought that's why I'd be sort of more on like an acute ward, busy, busy, busy, but I had one patient on there, and the interaction with his family and just his nature and the way he coped and the sort of relationship I built with him was like nothing I built with any other patient really, and I just thought [SP] it was something I was better at than I thought I'd be, because he got quite a lot of bad news in a short space of time and I was better at talking to him than I thought I'd be, cos I thought I'd probably go to pieces, but I was actually quite good, but I was only - like just turned nineteen at the time - and he [SP] he did use me as his reliant, because he came in and people were saying he's quite grumpy, but really he knew what was going on with him better than anyone else, and he was scared, and that's why he was grumpy, but because I was so new to it, I couldn't really do anything about the pain [SP]. I couldn't really do anything else except talk and he sort of [SP] the only person he wanted to go with him when he got his diagnosis was me [SP]; he didn't want his family or anybody, so it was like a positive thing and it changed my career path entirely. I didn't have anyone else that I met through my training that was like a palliative care case either, but he did sort of alter my way of thinking."

During his nurse training, Graham had found himself developing a preference for oncology and palliative care nursing and had actively sought suitable placements:

"... I wanted to do, um, oncology nursing, sort of stroke palliative care nursing, and I think I had [SP] and I think during my training I had [SP] I had very strong leanings towards that. I had pushed, you know, very hard, and very unusually got sort of [SP] you got to choose a number of placements and I managed to get an oncology placement as a student and also a placement, sort of on the HIV and AIDS unit. So that's how I got [SP] you know, I had quite a firm idea of what I wanted to do."

Jonathan had found elderly care enjoyable, as he had been able to relate well to elderly patients, although his feelings concerning this specialty were not completely straightforward:

"... the one place I <u>really</u> enjoyed working was care of the elderly. But the one place I couldn't <u>stand</u> working was care of the elderly. So it was this irony - I was [SP] again, I did a really good job in care of the elderly as well as the children's ward...

AS "What were the positives and negatives of [elderly care]?"

JP "The ability to relate to people, um, I think it suits my sense of humour, which can be a little dry. Um, but the people that you were joking with [SP] the patients [SP] were quite robust enough to come back at you, so there was often a nice bit of banter."

AS "You mean robust enough (SP]?"

JP "Sort of psychologically. The sort of [SP] most people if you joke with, um, in places like care of the elderly, will [SP] will joke back, because they have that [SP] most people - obviously there are those who, um, psychologically have [inaudible] confusion [SP] stuff like that, impairment, but [SP] yes, that was [SP] it was a good ward to work on, um, and I really [SP] I actually enjoyed it despite myself."

Felicity said she had enjoyed gynaecological and medical nursing, but that orthopaedics and dermatology had held less appeal for her:

"... I mean I liked gynaecological nursing and I liked medical nursing. I liked all aspects of nursing, but I didn't like orthopaedics and dermatology. [SP] Those were the two I didn't like."

AS "What was it about those that you didn't like?"

FY "Orthopaedics - I'm not very good at broken bones [laughs] and dermatology, it was just [SP] I don't know, it was just [SP] at the time I was quite young, and it was a lot of young men and having to put creams on them and that [SP] I just didn't find it particularly [SP] I didn't particularly enjoy it. But I think as a student you weren't encouraged to do too much, anyway."

Steffie, who had trained in Australia, had been put off neonatal nursing by her experiences in training and had also not enjoyed the experience of working in a plastic surgery ward:

"... I didn't like my surgical placements. I didn't enjoy that atmosphere at all, or getting dressed up to come to work wearing your lipstick and your makeup and your high heels and your short skirts to come to a plastic surgery ward."

AS "Why was that necessary for a plastic surgery ward?"

SZ "I don't know. I don't know why, but all the nurses that I worked with who'd been working in plastic surgery for a long time dressed that way... maybe it's just where I worked, and it might have been the age group of the people that I worked with as well, showing off to the surgeons and dressing up particularly [SP] yes, maybe that's what it was."

Janet had actively rejected midwifery after a negative experience in training:

"... I was quite interested in it but doing it so early put me off, because I didn't know what was going on... it was overwhelming, and the births that I saw [SP] perhaps they weren't that difficult but they just seemed like really difficult births and it just seemed - I thought 'I don't want to do that.' There was a midwife who was telling me [SP] she cried in the car, telling me that, um, about a baby who died 18 years before and I thought 'God, she's still really affected by that. I don't want to do that.'"

Marina, who set out on her nurse training intending to become a paediatric nurse, had quickly changed her mind and transferred to adult nursing:

"... I was actually quite set on being a paediatric nurse... for a while, but I decided against that really when I started my course, cos I initially enrolled as a children's nurse, but I just found I'd definitely be taking that home too much with me. So I started that and quickly transferred to being an adult nurse."

Two other nurses, Steffie and Grace, had also been put off doing children's nursing by their training.

Grace had enjoyed medical nursing, but had not liked her surgical placements, finding them "boring":

"... I liked medicine. I'd done surgery through my training and I just didn't like surgical patients. I just didn't [SP]. You know, they'd come in and have their operations, and then they'd go again and I just [SP] I just preferred [SP] I just enjoyed... I found it a bit boring, surgery. With medicine, there was always something going on - there was always some crisis or other."

Teaching on death and dying and experiences of deaths in training

It seemed that, while respondents had received little formal teaching on death and dying, in some cases positive and negative encounters with death had been key events influencing the development of nurses' 'being-towards-care'.

Thirteen of the nurses said that they had had very little or no teaching input on death and dying in their nursing courses.

Kerry, who began her training in the late 1970s, recalled that when she was a nursing student, it had not been considered necessary to include any teaching on death and dying or palliative care:

"...when there was a death it was [SP] you just dealt with it, really, and it was [SP] it wasn't <u>like</u> it is now [SP] they didn't [SP] there was [no teaching] about palliative care [SP] they hardly mentioned the word palliative care then - somebody was dead, and that was it. There was no talk about it. Do you know what I mean? There was none of that. Somebody's dead - let's move on to the next one."

Susan, who at first said she had not received any teaching on death and dying, did recall some teaching on the subject, but felt this was a topic area which was not easy to teach in an academic or theoretical way:

"I think we used to get a half hour slot, and you know, trying to teach a hundred and twenty students about death is not easy to do cos it's like, how can you do that? Because a lot of it's experiential [SP] talking about it, and you can't do that with a hundred and twenty students. And most of them ended up in tears or walking out cos they found [SP] obviously it hit something very personal to them when you talk about it. And you try at the beginning to say [SP]. But, you know, you talk about death and dying in any way, you're going to have - it's going to impact on somebody."

Stella, who had trained in the 1980s, attributed the fact that she had received little training on death and dying to the relative lack of development of palliative care at that time:

"There was a tiny amount into death and dying, but palliative care was a sort of [SP] a discipline that was only just developing while I was doing my nurse training, really. There was a bit about death and dying, but not a great amount. I suppose in that course, we did medical sociology, um, we did do psychology as part of it [SP]. It was a heavily medical science based - biological science based course - but we did [SP] we did do that and my [SP] my supervisor for my dissertation was a medical sociologist [SP] and a nurse."

Three respondents indicated that they did not recall having experienced many deaths of patients while undertaking their training. Marina said that she had not had an opportunity to get to know the patients who had died while she was a student:

"... it tended to be more elderly people who came in quite unwell in terms of [SP] you couldn't really get to know them as people [SP] you knew them as [SP] as their illness, really [SP] like you'd know their families and stuff, and [SP] but you'd know more about them from what their families said they were like as opposed to making your own relationship, so it was a bit different to actually coming to the hospice really and sort of meeting people for a period of time, because often, in my experience when I was training, they're often too unwell to get [SP] to let you get to know them, so you're sort of keeping them comfortable, but that's all you sort of know."

Four nurses recalled having experienced a large number of deaths during their training.

Alice's training experiences had suggested the need for a better way of nursing dying patients:

"... I just thought it [SP] there must be, like a better way of [SP] of helping people, really, and recognising their needs and [inaudible]."

Mark described graphically the deaths of patients for whom he had cared during his training:

"... lots and lots of them died - this was general hospitals. To give you an example of something that we had all the time, we used to have something called H and M, haematemesis - vomiting blood - and melena - passing blood. And it was because this was before the drug cimetidine was invented, and they would come in and they'd bleed to death, you know, and these were young men, very often, and they would just bleed and you would be there - this impressionable young lad as I was, in these awful situations with these men vomiting to death or [SP] or bleeding to death...That was one example. Another one was [SP] inevitably, people would come in with heart attacks and things, and we'd just lose them. I understand the success rates aren't all that much better than they were then, but there was a lot of death, and certainly [SP] and one medical ward I was on too, there was a whole section for psycho-geriatrics and geriatrics, and we lost them too - they would die. They would die all the time."

Alison recalled not liking the way in which death was dealt with in hospitals she had worked in during her training:

"I never liked the way people were taken away from hospital wards, I do remember that vividly as a student, er, [SP] I always thought it was very barbaric, the way it was done."

AS "How was it done?"

AM "Well, I can only reflect on what it used to be. I'm not sure if it's still the same, but they had a system where you had a coffin lid box - like a big metal box on wheels, basically, with a lid on, that the body was just sort of thrown into, the lid over the top, with a [inaudible] sheet over the top. And

I just always felt that that was done very coldly and very sort of matter of fact. So it did strike me, as a student in those days. [SP] Palliative care here, you do it so, so differently."

AS "How do you do it here?"

AM "Well, streets ahead of that, I can tell you! We [SP] patients stay in their beds and the bodies are laid out in their own pyjamas and nighties. Families tend to choose what they would like their loved ones to be laid out in. They have a posy of flowers put on their pillow, the sheets are all renewed, obviously, at that point. We then transfer them down into the mortuary. The nurses do the transferral of the body into the mortuary fridge, but it's done in a very dignified way, so it's very much part of the process that we are involved and looking after the patient right until the end."

A number of the nurses vividly described the ways in which their experiences of death in training had affected them. Two respondents recalled that their first experience of death during their training had been essentially positive.

Elaine remembered having seen the death of a child while she was a student nurse as having propelled her towards working in palliative care:

"She had, um, cancer, in her muscle and it went into her bone, and she died on the ward, um [SP] and some of the nurses were absolutely fantastic to watch. You know, the way they spoke to the parents, the way they spoke to her, and that sort of thing, and they did kind of encourage me, even though I'd only been [SP] I was - what? Seventeen and a half [SP] and they did encourage you to [SP] to see her and help to lay her out, and that sort of thing, and it was [SP] quite phenomenal, really, at that age. And I can remember not crying until quite a long time afterwards, and I wasn't sure why I was crying because she wasn't my child [SP] she wasn't my sister. Um [SP] I think purely because she was [SP] a teenager, and I kind of related to her a bit, being a teenager."

Four of the nurses recalled that their first experience of death during their training had been essentially negative. Susan recalled having been very distressed when she first encountered death on the wards:

"... I'd never seen anyone dead before, I'd never seen anyone dying and I'd known this woman for several weeks and the staff nurse said 'Oh, if you go in and get things sorted out...' And I said to her 'I've never been with anyone who's died before' and she said 'Well I'll be in in a minute, so I'll meet you in there.' And it was a horrible experience - I remember it - and it was a very difficult experience and I went in there and she'd been resuscitated and so she still had all the tubes in and everything from where they'd resuscitated her and it really distressed me in a bad way and it was things like, they never told me that when you move them that they would groan and - because of the air in the lungs and things like that - and that really distressed me. And I remember going home, and there was no support by those [SP] by the charge nurse or staff nurse that I was with at that time and I remember going home and I said to my mum ' That's it - I'm not doing any more. I can't do it. If I can't deal with death, then I can't be a nurse."

Diane recalled her first death experience very clearly:

"Yes, it was a man [SP] a young [SP] well, he didn't seem young to me at the time, but I'm sure he was - he was probably only in his thirties or forties and his name was Mr Preston. And he had, um, cancer of the oesophagus, and, um, I remember him being admitted to the ward with his wife, and he was coming for surgery, and in [SP] well, they still do now, for some cases [SP] but in those days they did these very radical operations where they removed the oesophagus and did some plumbing [SP] and the stomach and linked up some of the gut to make a new [SP] some kind of a feeding passage. And I remember - I don't know if I went down to theatre to watch the operation - I don't think I did, but I remember him afterwards, and I remember him having a wound from there right round the whole of his thorax, cos they went in through the ribs. And I remember him afterwards [SP] he was a very, very nice man - I liked him enormously - and he was in terrible pain. It was dreadful, and he got an infection - a wound infection - and it was <u>really</u> bad. And I remember the doctors [SP] I remember being in the office. This was my first ward, so I was only about eight [SP] well, I was eighteen. And I remember the doctors saying that they didn't [SP] they'd tried all these antibiotics, and they didn't know <u>what</u> to do, and they eventually got some really fancy antibiotics that they were going to try. And I remember the conversations and the worry and everything, and then he died. I wasn't [SP] and they didn't attempt to bring him back [SP] they

didn't attempt to resuscitate him. And I was on the ward, and I remember the staff nurse coming and saying to me, um, 'If you want to see your first body, you can see him.' And I said ' All right then'... and going in to see him, and seeing the nurses laying him out [SP] and they were taking the chest drains out, and I remember them pulling them out and whacking some plasters over them and just seeing this sort of wax face, and not really being particularly upset - just a bit numb about it [SP] I don't remember what I felt, but it was pretty, you know [SP] shocking, really."

Training placements in hospices

The option of a training placement in a hospice had only been available to nurses who had trained comparatively recently. Three of the nurses mentioned that they had not been offered this opportunity in their training but five had taken up a hospice placement during their training. Sandra said she had taken an option module which had brought her to work in the hospice in which she was now employed and emphasised hospice's focus on 'caring' rather than 'curing':

"I did a placement here as a student, I enjoyed it, and I kind of knew, um [SP]. It sounds [SP] I think [SP] it sounds a bit of a cliché, but comparing to working on the wards in hospitals, you see that [SP] and not just medical teams, but nursing teams [SP] you see that perhaps people see what's wrong with someone rather than the person, and I guess I kind of thought that, maybe palliative care... maybe there isn't so much medical intervention that we can really do. It's nursing care they need, rather than so much treatment."

Barbara identified the availability of time and the opportunity to provide holistic care as important attractions of hospice work:

"I actually did a placement over a year ago at _____... and that was just a four-week placement. But I'd already decided [SP] I already [SP] we were given [SP] in our second year, we were told we can choose a last placement, which is a 13-week placement, and we weren't guaranteed to get it, but [SP] and [SP] but I'd already put down to come to the hospice as my placement."

AS "And had you done any other placements over your three years? Had you done any other [SP]?"

BU "Palliative care? No, no. I mean obviously we'd had people dying on the acute wards which I [SP] I didn't always feel comfortable about the way they were cared for."

AS "Can you say any more about that?"

BU "Um, I just think [SP] I don't think the nurses have the time - I think that's the biggest thing, and I think that's what, to me, working here you have the time to spend and [SP] and I don't think the nurses have the time to listen to what patients are saying, and to be there for the relatives again."

AS "So is that an attraction?"

BU "Very much so, yes. I mean [SP] I knew it [SP] yes it was [SP] I always knew what I wanted to do, but also I think when you [SP] in your nurse training you're taught about holistic care of the patient, and that doesn't happen all the time on an acute ward - people don't have the time."

Two respondents mentioned having visited a hospice - one did so whilst in nurse training and the other after having qualified. By the time she qualified as a nurse, Christine had had some idea of the "ethos" of hospices. On a visit to a hospice she had been particularly impressed by the emphasis placed on caring for members of the nursing staff, as well as for patients and their relatives:

AS "And was there anything in particular about hospice work that attracted you to it?"

CG "Um, I think by the time I'd qualified I'd got the kind of the idea of the whole ethos of hospices and palliative care, and I'd had a visit as a student with a group, um, to one of the hospices...I remember they talked about massage and it was [SP] 'We normally have massage for the staff as well' and although it wasn't that that specifically attracted me, the whole idea of looking after the

staff, um, as part of caring for everybody, um, was [inaudible]. Yes, as part of the ethos I thought it was quite welcome, really."

Nurse training as a factor in choice of hospice nursing

Some of the nurses recognised aspects of their general training as having influenced them in their choice of specialty. Five said that having had a placement in a hospice while in training had led them, at some point in their career, to seek hospice work and of those who returned a completed checklist, 13 (45%) stated that experience in nurse training had strongly influenced them in their choice of hospice nursing (see Appendix 8). Alison, now a nurse manager, observed that it was quite common for nurses who had worked in her hospice as students to return to work there when they had completed their courses:

"Quite often the student nurses also will have worked with us here on placement and had very good mentorship. I mean quite a lot of support as well, within the ward area that they take that experience back and really think they'll need to come back again [?] So I have more recently recruited two of my student nurses that are now qualified, so that we're sort of developing them really from quite early on, which is quite an interesting initiative."

Nine nurses referred at interview to other aspects of their training which had been influential in bringing them to hospice work. For some, it was a recognition that death could be better dealt with than was possible on acute NHS wards that had moved them towards hospice care. One experience of nursing a cancer patient had had a profound effect on Christine:

"... I can't remember what her primary cancer was, but she had [SP] um, spinal involvement, and was in a lot of pain in her back, and we were giving her Oromorph for the pain, um, and it wasn't really working and, um, we just assumed [SP] I just assumed and got no other suggestion from any of the nurses [?] that that was how it was going to be... And then a liaison nurse from the community came in and, um, said 'Why hasn't she [SP] hasn't she been referred to the palliative care team for a start? Why hasn't this happened, that happened?' And, um, I didn't even know

there was a palliative care team [inaudible]. So [SP] and I've never forgotten that lady and [SP] and basically, the suffering that um, that she went through because of our ignorance."

In her training, Carol had become aware of bereaved relatives as distinct objects of nursing care and vividly remembered having supported a bereaved family as a student:

AS "Was there anything in your training itself that would have interested you in palliative care...?"

CE "Well, there was one incident which I will relate very quickly. Which was basically, a bloke who, on my very first ward [SP] don't forget, I was a first year, so didn't have much experience of nursing [SP]. It was an old bloke, a very, very [SP] in a very, very bad way [SP] demented, double amputee, blind, deaf, everything, who died during the night and when I came on duty as a student nurse, his body was still in the bed and his, um, daughter who'd been looking after him for years and years and years was sitting with him and she was incredibly distressed, and I took her [SP] she was so distressed that I took her away and sat with her to talk to her. And I told the night staff, who were just handing over, where I was and what I was doing, but I omitted to tell the day staff and so I was sitting with this woman and basically listening to her and I arranged for the chaplain to come and speak to her and, um, in the meantime, the day staff didn't know where I was and hadn't been told, so they thought that I'd been so upset by this man's death that I had run off to the nurses' home whereas, actually, it was just the opposite."

AS "You were being the support."

CE "I was being the support because nobody else was!"

Choosing a specialty

Having successfully completed their nursing courses, the newly-qualified nurses now had to make decisions about the specialty in which they wanted to work. Fourteen of the nurses indicated either that hospice (or palliative care) nursing had been their specialty of choice after completing their training or that they had felt a desire to do hospice nursing from some point during their training.

Palliative care is frequently regarded by nurses as a specialty which requires maturity and is not 'appropriate' for newly-qualified nurses, and this was one reason why not all the nurses who had felt a desire to work in a hospice on completing their training went straight into hospice work.

In her early twenties, Catrina thinks she is seen by many of her colleagues as "very young" to be working in a hospice. Having gone straight from school into nurse training and straight from training into hospice work, she is a relatively unusual hospice employee:

"... a lot of my colleagues think I'm very young to be working here and a lot of my colleagues are quite shocked that I've come here newly qualified as well. And a lot of my colleagues say to me that I should [SP] I'm young, and I should go and experience other things and then possibly come back to this. But I'm headstrong, and if I know what I want [SP] to be honest, I could see myself here for the duration. But it's just generally, other people say things to you and it gets you thinking sometimes, but I can really see myself being here for longer than a year."

Graham knew by the end of his training that he wanted to do oncology or palliative care nursing, but followed recommendations to get more general experience first:

"I think there's a strong [SP] and there remains a very strong, um, feeling in nursing that [SP] that this kind of work, you shouldn't [SP] is too specialised and you shouldn't come into it straight from your training and [SP] I mean I think [SP] I mean, for me, I [SP] you know, I just think well, you know, if you're certain, you know, and I think if you, you know, if you can show that you know that you're certain, I don't think that [SP] I mean I don't value the six months, you know, and literally, I was told to get six months' experience, and that's all I stayed for. Um, and I don't [SP] I didn't value that experience at all. I didn't [SP] I didn't think I learnt anything extra from what I'd been doing and it was really just [SP] it was almost like a penance that you kind of had to do this... "

Those who had not chosen hospice work after completing their training went to work in a variety of other specialties.

Jenny felt that experience in accident and emergency and undertaking midwifery training were essential in her quest to be a "rounded nurse":

"... I was attracted to accident and emergency, and then I know I wanted to go on and do midwifery, because I felt that was what you needed as a rounded nurse. I didn't feel that you could be a nurse, in the full sense, if you saw an accident and didn't at least know how to do something, or if you saw a woman go into labour and didn't know how to manage it. I felt you needed to be able to do those things, rightly or wrongly."

Diane took an operating theatre job after completing her training:

"... when I qualified, um, I left _____because I married in my third year, so I wanted to get out of _____, so I went to work in, um, a hospital in _____ - a little orthopaedic hospital - in the operating theatres. I've no idea why. I've no idea at all. I can't tell you why I did that. But I quite enjoyed it [SP] but I was pregnant at the time - I didn't know I was pregnant. So I worked there, on and off, through, you know, maternity leave and so on, for about four years in the operating theatre. And then after that, I went to work at _____Hospital as a full-time staff nurse, er, in an orthopaedic ward - a male and female [SP] a massive trauma ward, which was a real shock to the system, as I was really only just qualified in a way."

Two respondents said that they had found themselves having to decide between two almost equally attractive specialties at the end of their training. Catrina had faced a dilemma when applying to universities, only deciding when she got her A-level results that she would do nursing rather than physiotherapy. Having qualified as a nurse, she again found herself having to choose - this time between working as a practice nurse and working in a hospice, both of which she had enjoyed during her training:

"... I thought to myself 'I think it'd actually be better for me to go into an environment where I'm more in a team' cos practice nursing is more autonomous, isn't it?... So I thought 'Let me just come in [SP] I can always go back to practice nursing.' But [SP] I don't know [SP] I just felt more of a strong sense to work in palliative care."

Experiences and perceptions of other specialties

Following their experience gained through their years of training, almost all the nurses had gained post-qualification experience in specialties other than hospice care and their experiences and perceptions of the specialties frequently emerged as topics during the interviews.

Accident and emergency

Six respondents referred to their experiences and/or perceptions of accident and emergency nursing. Although he had been working in hospice care for many years, Mark felt that accident and emergency nursing generally had a more positive image than hospice nursing:

"...ITU is sexy. A and E has become sexy. Palliative care was never ever sexy. It was sort of a place where people who were kind of, you know [SP] not particularly career orientated [SP] cos it was a bit of a career no end, really [SP] a bit of a cul-de-sac..."

Jonathan had very much enjoyed working in accident and emergency as a student, and went to work in that specialty after qualifying:

"Um, I was quite brave. I went straight into accident and emergency, which I excelled at as a student [SP] and [SP] went straight into a job there, was on a rotation course so you did three areas, um, to gain a maximum amount of experience. So I couldn't get on a ward cos they were full up so they gave me accident and emergency as my first ward. Um, and that was fun - that was very exciting. It made me realise that I needed certain skills that I hadn't actually acquired because I'd not been on the wards, which was a really silly thing. So I went into there and then after six months I moved into intensive care, again because there was no room on the wards for nurses..."

Christine had never been attracted to accident and emergency:

"... I always knew I wouldn't be the kind of nurse who would thrive in somewhere like accident and emergency when, um, you know, you've got to kind of whizz around the whole time and cope with all sorts of pressures."

Community nursing

Five nurses had gained experience of working as community nurses (either as district nurses or as health visitors or both) and one had wanted to do district nursing but had been unable to do so because of the drop in salary that would have been necessary for her to do the required training.

Having met some Macmillan nurses[13] while working in a hospital, Elaine had aimed to eventually become a Macmillan nurse herself and had taken deliberate steps towards this aim:

"... so I went and got four years' community experience. Got accepted on the district nursing course, which was a degree course at the time, which was quite a tough interview, actually... and I got accepted onto it, which was fabulous. I was so thrilled. But at the time, I was an F grade and my salary was sort of OK, and they said 'To do the degree course, your salary has to go down to a middle E.' And I couldn't afford to do that, so I had to turn the place down. So I was very disappointed about that."

Janet had undertaken a health visiting course and had enjoyed working in the community:

"I really enjoyed working in the community and I really enjoyed working with families, and that's one of the things that I enjoy about hospice is working with families."

Janet saw parallels between health visiting and hospice nursing:

"... the health visiting is about the beginning of life. You're going to visit people who've just had their babies and, um, and seeing them, you know, with very young children, whereas the hospice is, yes, it just felt like it was about endings... It's similar [SP] it's not helping them into the world, but it's [SP] it is in a way, it's helping, you know, particularly, um, new mothers, to make that transition from being on their own to [SP] to having their baby and having to care for it. "

[13] Macmillan nurses care for patients with cancer in their own homes

Emily had worked both as a district nurse and as a health visitor and it was while working as a district nurse that she had encountered a palliative care team and was encouraged to leave district nursing to join them:

"I worked as a district nurse, and then I worked as a health visitor, and it was during my time working on the district that I came across the evolving palliative care team down in _____and used them for my patients, and then did a side-step and joined them, sort of thing."

Caring for terminally ill patients in the community as a district nurse had moved Gordon in the direction of hospice work:

"... the thing I like about the community is that you're seeing the patient as very much part of the family, of the situation, whereas, you know, on the ward setting in a hospital [SP] even here, you know [SP] not so much here, but [SP] people can [SP] you can lose your identity in that way, you know [SP] you get into your pyjamas and a dressing gown and everyone can be the same really, so, um [SP] but I enjoy the sort of home contact and seeing people as part of a family."

Kerry had started working as a district nurse as it had been flexible enough to allow her to pick her children up from school and had very much enjoyed it. Eventually however, she had left to do hospice nursing, having found herself overburdened with work, unsupported by her staff and engaged in a fight against falling standards of care:

"A lot of nurses in the office they [SP] they didn't bother about things like I did - like, it's a bit strange really, like the stores - they couldn't be bothered about the ordering and if we didn't have the supplies there, how were we going to do the work out in the community? So I ended up getting the [SP] having to do all the ordering and then, um, nobody wanted to tidy the [SP] or [SP] the cupboard, when the stores came in, so I used to have to do all that, and I couldn't delegate - I tried to delegate and nobody wanted to do it, and they always used to say 'Oh, Kerry'll do it. Kerry'll do it.' And I didn't mind doing it, but anyway, trying to cope with your caseload at the time [SP]. And then I was thinking [SP] there was lots of changes going on with the community. Not as much as

there is now, but there was developments within it... And I thought 'Hold on! What...', you know, 'I just want to do my work here.'"

Elderly care

Four nurses referred to experience or perceptions of working with elderly people. Alison had started her nursing career working in this field, but staff shortages and difficulty in getting stock had led her to seek a hospice environment in which she felt she could nurse as she had always wanted to:

"I started life as a staff nurse with very little experience from a palliative care perspective, having gone from care of the elderly into palliative care doing two nights a week [when her children were young]... I had gone... from care of the elderly where the unit itself had become quite run down, the stock wasn't there, there was a shortage of staff. [SP] I became feeling quite disillusioned by nursing."...

"I loved [elderly care] [SP] I loved working with older people [SP] you know, the elderly folk [SP] I just love it - you get a lot out of it. Um, but it became very frustrating because I just couldn't carry out the nursing care that I felt I wanted to, and because I'd got to that stage, I felt 'No, I've just got to try something else.'"

Intensive care

After qualifying as a nurse, Jonathan had chosen to work in accident and emergency and went on to gain substantial experience of working in intensive care. He had experienced the ITU in which he had worked as very stressful and as an environment in which nurses could quickly "burn out":

"The _____(hospital) was OK - just very fast-moving. Even at night time it didn't stop - you know, it was just [SP] it was the same pace but with the lights on. So it was [SP] very difficult, but good experience. It taught me that if nurses don't watch what they're up to, and don't look after themselves, they burn out and they're no good for anything, which is not what you want, really... the senior nurses were always running on crisis management, and therefore didn't have the time to

sit down and [SP] and I realised at one point that I was starting to burn out, cos I was trying to do lots without really, um, feeling supported. Um, and in the end, sadly, I just chose to leave, and [SP] it was almost like 'Oh well, never mind, thanks for coming.' Which has left me feeling quite bitter."

Mark had very much enjoyed working in intensive care, specifically because he felt that he could "make a difference" to patients and was granted a good deal of autonomy by the doctors:

"... I left where I trained... And I went to _____ ... ITU in a new hospital they built there... and I absolutely adored it. I did the intensive care course, and then I worked on ITU afterwards, and they liked me and I was promoted [SP] and I absolutely adored it, but again, what I adored was the fact that I was with a patient, on my own, and I could make a difference, and you really could make a difference there.

Amy had also enjoyed working in an ITU, where she had felt she had been able to give "really good care" and to put into practice the principles of holistic nursing:

AS "And what was it about ITU [SP]? There must have been something that attracted you to that."

AC "... You can [SP] you can give really good care - it's all one-to-one - and you are [SP] it's your patient and you're responsible for that patient and the relatives and the whole [SP] the whole holistic ethos thing about... there was something about [hospice nursing] that just seemed to be very similar to my intensive care nursing."

Macmillan nursing/community palliative care nursing

Macmillan and Marie Curie nurses work with cancer patients in their homes and fulfil a similar role to community palliative care nurses based in hospices. Three of the nurses were currently working in the community, although all of them had had substantial experience of working with hospice in-patients. Susan, now working with in-patients, had worked as a Macmillan nurse before coming to work at the hospice:

"... I was a Macmillan nurse, and then I got asked if I'd apply for a lecturer/practitioner post here. So I got that post and did that for about two years and then this job came up... and so I applied and got that post."

Medicine

Medical wards in the NHS care for patients who are ill or require hospital treatment, rather than for those requiring surgery. Six of the nurses made some reference to having worked on medical wards.

Elaine had not enjoyed her post-training year on a gynaecological surgical ward, and after travelling abroad for three months, had decided to try medicine:

"... I thought 'Oh, I'll go into medicine.' So I went on to, um, a medical ward for a year, which I really loved. That was [SP] that was a good time... I really enjoyed that. I learnt a lot."

Midwifery

Four respondents had trained and worked as midwives at some time during their working lives. Several others had considered doing midwifery but, for a variety of reasons, had not done so. Patricia had at one time thought about doing midwifery, but had eventually rejected the idea, seeing it as lacking the necessary stimulation and challenge to keep her interest:

"... I had thought about it, because I had my midwifery training at the end of my first year and we only had two weeks, so we had a week in maternity and then a post-birth special care baby unit, and we did follow a couple of babies through that journey - one that was a heroin addict and one was, um, a very severely deformed baby that was born. It was so sad, and seeing all of it that, it [SP] just amazing - all these experiences happen every single day, and you don't really know about it. And again, I think that's something I would enjoy doing, but I see midwifery as being too [SP] now I see it as being too repetitive - too much of the same. I mean that sounds awful, cos every child is different, but there must only be so many variations of a birth. Which in its own way would mean you can become quite an expert and develop your knowledge base probably quite

quickly, but now [SP] I don't know that I would see that as a challenge for long enough, bearing in mind that I'd have to do another eighteen months' training, so that's the balance, really."

Carol had wanted to do midwifery, but had also been attracted by hospice work, and when a hospice post was offered, she took it up. After just over two years in the post, however, she realised that she still wanted to do midwifery and worked as a midwife for several years. Eventually, however, she left because of the stress of heavy workloads and staff shortages to return to hospice work:

"... I left midwifery at the beginning of 2000, basically because I couldn't stand the stress of having so few midwives and so much work and there was a huge shortage of midwives [inaudible] for various historical reasons in the late nineties, and I just felt that, you know, it wasn't for me any more, I wasn't enjoying it any more... Working with the dying is not a stressor for me. Working in a high-tech, whizz,whizz emergency, life-and-death environment is, and I'd had enough of it."

After her general training, Jenny worked as a staff nurse on a male accident ward for eighteen months before doing her midwifery training and working as a midwife for several years. She very much enjoyed this work, but eventually left because she no longer felt able to provide care to the high standards to which she aspired:

"... I loved midwifery and that was the sort of beginning of life, and I loved it at that stage because we could do it really well, and I did it to a very high standard, and you could feel very proud of the way that you worked. But midwifery isn't like that any more, so I knew in my heart that probably I was looking for something that I could do to a similar standard, and that's what I found in palliative care."

Seven of the nurses identified links between midwifery and hospice work. Carol, who had worked as a midwife for some years, observed:

"... there are lots of similarities between midwifery and palliative care [inaudible].

AS "Yes, a lot of people seem to have described palliative care nurses as midwives to the dying."

CE "Yes, absolutely [SP] it's very connected."

Elaine compared the vulnerability of those coming into the world with that of those who are in the process of leaving it. A woman with whom she had worked at a private hospital had asked why she did hospice nursing:

"And I said 'I don't know. I think that I just do the opposite end of the scale to what a midwife does'...' I sort of think I just do the opposite end to what they do, really. And somebody that's leaving the world needs just as much care - if not more - than someone who is just coming into it, because a baby - we think, we don't know - is unaware of entry into the world, whereas somebody who's dying [SP] often, they know they are, and it's a [SP] must be a really frightening [SP] one off, never to be experienced again."

Angela had done her midwifery training in the late 1970s and worked for several years as a midwife:

"... somebody said to me one day 'You've gone full circle - you've gone from the womb to the tomb' which I thought was actually quite a nice way to put it. I suppose when you've got a woman in labour, she's on a journey isn't she? She's had a nine-month journey, and then she comes to the end of her journey, and those last hours are the painful part of that journey but she gets something out of it. But you accompany her, um, and I feel the same in [SP] in terminal care. When somebody is dying, they are on the last part of their journey."

AS "So actually, the two have quite a lot in common, don't they?"

AQ "Yes, yes. Except that when the woman comes to the end of her journey in labour she's got a beautiful baby, um, where the person who's died in the bed, they are no longer aware, but the family are."

Oncology

Seven respondents said they had worked in oncology at some point in their nursing careers. Susan had felt "comfortable" working with patients dying of cancer and had felt that this was a specialty in which she had been able to give good nursing care:

"... by doing oncology I thought 'Well, this is something that we do provide.' So I think I just tried to find where I felt care was provided in the right way that I would want any member of my family to be cared for... and I definitely wouldn't find that on medical wards [laughs]."

Susan was one of four of the nurses for whom oncology had represented a way into hospice nursing. Christine had worked in oncology for nine months specifically with the intention of gaining experience which would be useful in palliative care:

"... my first job was in _____ Hospital. I did a rotation - nine months elderly care and then nine months oncology. And that was with a view to getting experience to go into palliative care."

Mark had worked at a leading cancer hospital but had found it very hard to work with patients who were involved in cancer drug trials:

"[It was] a bone marrow transplant unit. [SP] It was absolutely awful. We had a thing like this with all the names of the patients outside, and then on top would be the trial number of the drugs [SP]. There were different combinations of chemotherapy involved. And you know, you'd go along so far, and there would be a red dot. And everyone who was a red dot had died - the red dot equals death. You know, and I just couldn't <u>bear</u> this any more, cos all these guys when they came in were really ill..."

AS "Was it a randomised controlled trial?"

MS "Yes, yes, and they all died [SP]. They were all dying. They were called BF, and then they were given a number [SP]. I don't think a lot has changed. Anyway, it was brutal - <u>absolutely</u> brutal. The whole place was brutal, and there was no compassion from the medics there, and they were

just interested in pumping chemo and keeping people alive with blood [inaudible]. I'm probably doing them a great disservice, but I don't think so."

Orthopaedics

Diane's first job after qualifying was in the operating theatres of an orthopaedic hospital and she later took a job as a ward sister on an orthopaedic ward. At the time she remembered having had specific reasons for enjoying working with these surgical patients:

"So orthopaedics was what I did, because, um, funnily enough, I [SP] liked it because the patients didn't die on orthopaedic wards. And I said 'I like orthopaedics, cos they tend not to die - they get better and they go home and they [SP] you mend them.'"...

"Well, that's what I said. I remember saying it in a light-hearted fashion. I [SP] I don't know if I really thought that. I don't know what I thought, you know, in those days - I really don't - ... but certainly I liked the drama of it... you were very busy and running about and thinking on your feet and [SP] and I liked all that."

Surgery

Four of the nurses said they had enjoyed working in surgical settings:

"I enjoyed surgery very much and I found it absolutely fascinating looking after people, [SP] getting them ready for their surgery and nursing them through their surgery - their operations - and post-op. But it was not a holistic way of treating them at all. It was very much about, um [SP] almost conveyor belt. I mean some of the surgery we did was major surgery. I mean it was big, the patients were in for a long time [SP]. You know, the numinectomies, lung surgery, oesophagectomies - mainly for cancer, but it's there I got my knowledge of patients with cancer, and it's there I got my clinical skills, which has enabled me to do the jobs I do now."

(Stella)

Four respondents had not enjoyed surgical work. Elaine had found her work on a surgical ward "clinical" and had not felt able to interact with patients as she would have liked to have done:

"It was a gynaecological surgery ward so it was all [SP] you know, there were quite a lot of terminations and things like that, and the sister that was in there [SP] she wasn't particularly nice to the girls that came on [SP] she wasn't particularly nice to the student nurses, either - the first years... I think the fact that, with surgery, people coming in, they have their surgery, and then they go home and you have no affiliation with them. It's sort of clinical and [SP] you know, it didn't [SP] I just thought there's no [SP] I prefer the human touch and the [SP] the sort of fact that we are who we are and we get together and make social interaction, but when somebody is, you know, coming round from anaesthetic and [SP] you can't really do that, and they're off home when they feel better so it's just 'Thanks and goodbye!'"

Factors in choosing hospice care

We have already seen how some of the nurses recalled having moved into hospice work through their experience in other specialties. A number of other factors which respondents saw as having been influential in leading them into their current work were discussed during the interviews.

Images of hospice care

Most of the nurses interviewed (25) gave some indication of their initial images of hospice care. It was noted earlier in this chapter that some of the nurses who had developed a desire to go into palliative care work by the time they had completed their training had been recommended by teaching staff to get other experience before entering this field. It appeared that the idea of hospice as a specialty more suited to older, experienced nurses than to recently qualified individuals was quite widespread.

Elaine had decided, by the end of her training, that she wanted to work with people who were dying, but was aware that this was something best deferred until she had gained more general nursing experience:

AS " As you were going through your training, did you have any thoughts about the specialty that you wanted to go into?"

EA "Yes, I knew it was care of the dying. I think I knew from quite a young [SP] you know, from when I more or less started that I wanted to look after people that were at the end stage of their life, really. But knew, at the time, that it wasn't something to do when you were an inexperienced nurse. You had to have some experience behind you. That's why I left it, and got lots of experience behind me."

Diane felt that the nursing skills she had acquired in other specialties had provided her with the experience necessary to provide good palliative nursing care:

"... I found that the skills I'd picked up over the years came into their own in this setting more than anywhere else, and I could listen to people, I got responses, I could, um, I could be with people in their pain without feeling I had to make them better, and I could manage those sort of existential moments with people, and I know that it was my counselling training that helped me with that. I just felt like everything fitted into place, and I wasn't frightened of death, I was older, I didn't mind, I wasn't frightened of anything, I didn't mind making a fool of myself or asking stupid questions - so it just felt perfect."

Matthew, who had come into hospice work having had a great deal of life experience, observed that there had recently been an increase in the number of young people entering hospice work, which he found an "interesting development":

"I've just been working with a nurse who is only just qualified. Now what brings them to this place?... I've come to this by a long path, as have a lot of my colleagues here - that was the common way - we were most of us mature. But there's been an increasing number of these young people coming in, and I think that's a very interesting development."

Patricia had found her own life experience helpful in hospice nursing, but was prepared to accept that young people could have the potential to do well:

"I think the empathy of losing my mum [SP] I really think that's made me a far better nurse, because I'm not frightened to go into a room and say 'I'm really sorry but your mum' s just died' or [SP] I understand when to say something, when not to say something [SP] just sometimes, when it's appropriate to hold a hand or whatever, and I think that comes with experience - with your own experiences, definitely. But I've also seen other younger palliative nurses here that do equally well, so [SP] that's my own perception of how I am, I suppose."

Several respondents drew attention to the fact that hospice work was a relatively "unusual" area for nurses to choose:

"... I think I find it [SP] I suppose, a fairly unusual calling, and when you talk to, you know, sort of [SP] perhaps lay people, you know, they often want to know what would make you come into that type of work."

(Graham)

Marion, who had gone into hospice work after a career in catering, felt that hospice work had to be a 'positive choice':

"I think you have to want to nurse the terminally ill and be able to deal with death, so it's not a nursing environment for everybody, definitely, and I think when I worked in the acute hospital I saw that some nurses were uneasy around patients who were dying - they definitely preferred looking after the living. I do think you have to want to be in this type of nursing."

AS "So it's like a positive choice?"

MH "Oh I think so, yes, yes."

For some of the nurses, hospice work was attractive because it was "new" or "challenging." Jenny had been running a nursing home before coming to work in a hospice setting. Having registered

her home to take terminally ill patients, she had found herself taking on more and more people requiring palliative care. To her, hospices were "interesting" and "different":

"So it grew and grew, and then having opened it up for terminal care, then I had to [SP] we had to think 'OK, now we need syringe drivers, so then I need to send my people for training.' So from near the _____Hospital, I used to send them down here for training. Then I thought 'It's no good them all being trained. I need to go myself.' So I came down here for some training days, and I thought 'This is really interesting - it's different and I like it' and I don't know what it was about it. I wasn't afraid of it, um, I liked the fact that it was done well - the nursing and the caring, that it was well done - and so I became a lot more interested..."

Marina, who had gone straight from her nurse training into a hospice job, observed that to go into hospice nursing, individuals needed to think beyond the more popular specialties:

"... I think, to go into hospice nursing you have to think a bit outside your box really... people don't know where these places are, because death just isn't wanted to be known about really."

Diane had known about hospices, having heard about Cicely Saunders and having read her book. Her initial impression had been that only the very best nurses were chosen for this sort of work:

"... in those days they could just pick and choose what nurses they had [SP] and I remember thinking, you know, 'You have to be really good to work in a place like that' and when I did my, um, tutor's course or clinical teaching course - I can't remember which - they had someone from _____ (Hospice) come and talk to us and [SP] about the work of the hospice [SP] and I remember we [SP] I remember she brought a box of tissues with her because it used to make people [SP] and it was a wonderful presentation, and I remember thinking 'How marvellous' - you know these people [SP] and she [SP] and she indicated that the nurses were hand-picked, and I just never thought I'd be in that league really."

Emily, who took a 'sideways' move into hospice work from district nursing, recalled having been attracted to the work because it had seemed "worthwhile":

"I think I thought it was very worthwhile. I found [Hospice at Home] helpful in the care of the family and patient situation on the district, with my district nursing hat on, um, and their nursing directors, as they were then, sort of said have you ever thought of joining them? And I thought about it, and thought well actually, yes, I'd probably be quite interested, so [SP] as simple as that. I'd had a taste of it, and thought, well, yes, this is good - it is very helpful and I'd like to be involved in it."

Unlike that of most of the other nurses interviewed, Mark's first impression of hospices had been somewhat negative. Having read a book on hospices, he had been attracted to the idea, but his initial encounters with hospices has led him to question whether or not he was really suited to the work:

"I didn't have the impression that hospice was kind of a pukka thing to do, and the sort of thing, you know, you'd want to consider later on in your career."

However, he had made inquiries and visited a hospice, where he did not get a good impression:

"I really didn't get a good impression - I really [laughs] [SP] I can remember it distinctly, feeling 'This is slightly odd. This is slightly too religious. This is slightly off beam. I'm not sure this is for me. Yes, I want to look after the dying, but I'm not sure this is right'.

Shortly after this, Mark had signed up to work in a leading cancer hospital.

The influence of other people

Fifteen of the nurses made reference to people who had influenced them in their choice of hospice work. Elaine had been impressed during her training by the way some nurses behaved around dying people and their relatives:

"I think... it was the [SP], the role models and, you know, the way that you would see people behave around grieving relatives - bereaved relatives - and the actual dying person themselves.

And I always [SP] from quite a young age [SP] would [SP] not pretend, but I could almost see myself, or someone that I loved... in the bed, or in that situation, and think 'Oh my God, if I was them, I wouldn't want you around them, but I'd want you around them."

Elaine had also been influenced by a palliative care specialist nurse at a hospital in which she was working:

"... it was through her I [SP] I used to talk to her about patients on the ward, and it was her that said to me 'You'd be so good. Why don't you go for it?' As in, go to work for the bank[14] at the hospice, do your [palliative care] course and then, you know, go on to bigger and better things sort of thing. And so she's one of the reasons, because [SP] I kind of thought I would love to be like her, because she's just such a good nurse. She's knowledgeable, she's compassionate, she's caring, she's aware of staff needs [SP] patient needs [SP] you know, and she has [SP] she can communicate with all levels of people and I just thought 'I really want to be like her.'"

Graham remembered having been inspired by a male nurse he had met, who had suggested that he apply for a job at the hospice where he was now working:

"... he was a very dynamic nurse, um, and an incredibly skilled and caring nurse, um, but you balance that with, and you know, having a very sort of strong [SP] strong voice and actually I think just the influence of [SP] you know, actually was able to deal with situations [SP] the way that he was able to deal with situations [SP] actually, the way that he was a real kind of leader for nurses, really, and I think he really empowered nurses on the ward to sort of [SP] you know, to feel that they were important and valued, and actually that, you know, that a lot of the stuff that was happening wouldn't happen if the nurses weren't there to sort of feed it back and, you know, and sort of find out the information in the first place."

Some respondents referred to people other than nurses who had been influential in moving them in the direction of hospice work. The idea of working in a hospice had first been suggested to

[14] Nursing agency run within a hospital to cover staff absence

Christine by the chaplain of the university at which she had studied for an English degree and during her nurse training she had been particularly impressed by a palliative care doctor:

"... there was a palliative care doctor... when I was doing my training, who started [SP] I believe he was a care assistant, and then he'd [SP] I don't know, done nursing first [SP] anyway, you know, he'd started on kind of the bottommost rung and he was a consultant in palliative care, and a very caring chap, and, um, his team they used to come in and talk so gently - so differently from, um, the surgeons..."

'Push' factors

In talking about the routes they had taken into hospice work, the nurses frequently made reference to features of nursing in other specialties which they saw as having acted as 'push' factors, moving them away from NHS nursing and towards hospice care. The 'dichotomous conceptualisation' which was a marked feature of their descriptions of their journeys into hospice nursing is discussed more fully in the next chapter.

Ten of the nurses indicated that they had experienced dissatisfaction with the care they had been able to provide for patients while working in the NHS. Felicity had decided at the start of her training that she would like to work in palliative care and her training had reinforced that desire:

"... it just made me more determined that that's what I wanted to do, and actually when I worked on a medical ward, obviously, we did have some palliative care patients and I was becoming frustrated that we couldn't give the care that I felt they needed in that hospital environment. There was 32 patients with two staff members and it was very, very busy and you just couldn't give that care, and that was when I became frustrated and definitely made my mind up to come to a hospice."

Barbara, who started her nurse training at the age of 40, and who went straight from training into hospice work, had felt that she would not have been able to have provided the care she wished to give in the NHS:

"I think [my training] just helped me with my convictions in the fact that I did see what I thought was poor nursing care in people's [inaudible]. I don't know [SP] it's difficult [SP] you can't sort of like do everything, can you? I mean, I'd love to see good palliative care given in the hospitals, but I'll just do my little bit in my way."...

Five of the nurses referred to having felt 'frustrated' when working in other nursing specialties. Grace had worked on medical wards for 26 years and finally moved on to do what she had always wanted to do:

"... I'd always wanted to do hospice work, because I got very frustrated on the medical ward, cos you'd have 28 patients and always somewhere, tucked in the corner, was two or three, maybe, terminally ill patients who were waiting for hospice beds, who desperately needed your time and care - as did their relatives - and you couldn't give it to them, cos you were so busy on the medical ward... You just didn't have that time, and that was the sadness, I think."

Three respondents referred to the fact that in other specialties there was a lack of time for patients. Lack of time was one of Christine's main reasons for going into hospice work:

"Generally, it was a mixture of wanting to provide that quality care that you aren't able to in other areas, um [SP] I wanted to be in a place where there isn't all the mad rush and [SP] and the whole thing about resuscitation - that is a bit of an issue with me, really. Um and false hopes [SP] and er, yes, being in a place where there's a little bit less stress."

Three nurses said that technology had been one thing they had been pleased to leave behind when leaving the NHS to work in a hospice. Diane had disliked "rushing around" and using technology:

"... what I really like about [hospice work] is that, um, you're not trying to make people better, so all of your energy isn't taken with all these treatments and rushing around with lights flashing and trying to thump on people's chests and [SP] that used to terrify me in nursing - I used to be really frightened of that, and really, what are we trying to do?"

Two respondents related specific instances of uncaring behaviour by staff which had put them off working in the NHS. Marion recalled an event which had occurred when her terminally ill mother was in hospital:

"She was in hospital and she had said to my father, she said 'I know I'm dying, I want to go home. Can you get me home?' So he [SP] he organised that but it took a little time and I was visiting [SP]. I'd gone up to visit her, and my father was beside her bed, and I was there, and they came round with the meals. Now, it wasn't nursing staff, it was - I think - domestic people - domestic staff serving the food. And this tray was put in front of her, and my father lifted the lid up and he said 'Oh, excuse me, but I don't think this is a suitable meal for my wife.' It was a heavy stew, or something like that, and the response was really inappropriate. The response was - and I'll never forget - 'Oh, she should put her teeth in.' And we were so shocked, and I just really couldn't quite believe what I was hearing, and that stayed with me. I think you never forget, if you are in a state of distress, you never forget. An unkindness, or an unkind word. And I think, as well, that was one of the reasons for this [SP] wanting to work in this type of environment, because I think we are more careful about what we say and how we say it."

Two of the nurses cited encounters with doctors in other specialties which had been in part responsible for their move to hospice work. Marion had found some of the doctors on the acute wards she had worked on "rude" and "superior":

"I became dissatisfied with my role at _____Hospital. I just felt it was not what I wanted. I wanted to nurse, but I didn't want to nurse in such a fast environment where [SP] I know an acute hospital is needed and necessary, for people who are really [SP] um, really ill, but... some of [the doctors] were quite rude to the nursing staff. Instead of working as a team towards the same goal, they were quite, um, superior in their manner, whereas I think the doctors that I've met, the consultants that I've met over at _____[hospice] have a very different approach and a different attitude."

Two nurses said that they had encountered lack of support from other colleagues or superiors while working in the NHS. In her second week as a qualified nurse, Sandra had found herself taking on an unacceptable amount of responsibility and experiencing lack of support:

"... I was left in charge of a 30-bedded ward of neurodisability patients, and then I thought [SP] 'Yeah, I can't [SP] this is just [SP] I need a bit more support', and I was told you don't get a mentor - cos I was on the bank..."

For Alison, it was lack of funding for staff and equipment which had driven her away from working in elderly care:

"The main thing [SP] maintenance wise, if anything went wrong, you had to wait for things to be mended and you were put in [SP] you were put on the list, shall we say, because the porters, the maintenance men, would only [SP] were covering several hospitals [SP] several sort of institutions and it was all done in order of priority, where here, I only have to snap my fingers and it's done, it's sorted. That's one of the many, many things."

'Pull' factors

As well as discussing factors which they saw as having 'pushed' them away from other specialties in the direction of hospice work, respondents also talked about characteristics of hospice nursing which had served to draw them towards this work.

'Working outwards' from ideals

Nine of the nurses had seen in hospices an opportunity to provide good nursing care. Alison felt that nurses were attracted to working in hospices because of their reputation for providing care "in a different way":

"... nurses that come into palliative care [SP] tend to be coming in because they want to um [SP] because they are the caring sort, the ones that are good communicators, the ones that are good listeners that want to do good, hands-on nursing care. Um [SP] I think they [SP] some of them may

have experienced some bad deaths within the acute settings and they so desperately want to try to improve their skills on that, and know that hospices are renowned for doing it in a different way. So I do think some nurses come in with that yearning inside them, that that's what they want to achieve."

Mary, now in her late fifties, felt that people of her generation were drawn to hospice nursing because of the opportunity it gave to provide "real, basic nursing care":

"I think what draws somebody of my generation back into palliative care is that, in the old days [inaudible] as you know, patients stayed in hospital much longer... they weren't discharged home nearly so quickly, so you were doing a lot more for the patients. Now, patients, as you know, go home after 24 hours and there is a quicker turnover, and so you don't get to know the patients so well and you're not doing nearly so much for them, and also - and this is particularly applicable, *I* think, in care of the elderly where I did my return to nursing course - you're really encouraging - I would say almost forcing patients to do more for themselves, and you're having to take a backward route, and that [SP] I don't find that easy. I like doing things for the patient... and I think that's one of the [SP] the main reasons why I wanted to come into this field of nursing [SP]. We could still do real, proper, basic nursing care."

Six respondents clearly indicated that they had come into hospice care as an attempt to find a setting in which their ideals could best be put into practice. This process was summed up neatly by Stella:

"... I think the nurses who really want to nurse [SP] to nurture, to give care, to be at the bedside, this fits their philosophy, I suppose."

Matthew saw hospice as a place where he could practise nursing in a "purer form ":

"It was this [SP] it was this opportunity to exercise nursing in a way as I saw that it should have been applied in the first place. So in that sense, I wasn't looking for a specialist qualification, if you like, I was looking for nursing in a purer form."

Stella described how she had become aware of the constraints of the medical model and attempted to equip herself to nurse in the way she wished:

"... as I was reaching the end of the course, I was very aware of the constraints of the medical model, and very aware of the fact that actually I wasn't sure this was quite what I wanted to do and what I wanted to be... I took the job at _____in _____and whilst I was working there I started looking at various other courses where I felt that I could study and look at a more holistic way of treating people. And in 1989... I started studying [complementary therapies], so I was using my medical knowledge, because the course I did was very much medically based. It followed the same systems of diagnosis as the medical model did, but it was a very holistic assessment process... it used the medical model that I was very familiar with in my nursing practice, but it was introducing a very holistic medical model. And I continued to work full-time while I did the course."

Later, after undertaking further postgraduate study, Stella took a job in a hospice where she was able to put into practice what she had learned:

"So I was actually able to put the M.Sc. into practice in my workplace, and I was nursing in a holistic way - I was nursing in the way that I felt I could, and our consultant was very much interested in complementary therapies himself, and he was very [SP] he was very willing for me to use [them] in the hospice. I was finally tying everything together - everything came together. And I just found that [SP] the actual care [SP] the palliative care I was giving was just totally how I felt care should be. It was about [SP] I mean it [SP] I think I said earlier [SP] it was about being with people, it was about being at the bedside, and sometimes it's just about sitting quietly."

Having undertaken a conversion course (from SEN) to become a registered nurse, Susan worked in oncology for a while before moving on to hospice work. She had sought out this type of work as a setting in which she could put her ideals of nursing into practice:

"I think I just tried to find where I felt care was provided in the right way that I would want a member of my family to be cared for."

Focus on family care

Twelve respondents had been attracted by the fact that hospices cared not only for patients but also for their families.

Angela remembered having been aware of the need for family care:

"I remember being very humbled to see a family [SP] and I think I had qualified at this stage or maybe I was a student [SP] I can't remember [SP] but seeing a family around the bed of a dying man, and by this stage, this chap was in a coma - very comfortable. And it really hit me then that this family [SP] cos what would happen to his family? Um, and of course, as you know, in palliative care the whole family is taken care of. And I remember as a staff nurse doing twilight nursing in _____, and there was a lady - and I think she was coming to visit her mother in ____, and then as soon as she finished there, she was going to visit her husband in _____. And I remember seeing this poor woman - she was going to fall between the stools of two hospitals. Who was going to pick her up? But then hospitals don't pick people up, because they can't cope with those numbers. Um, so I think, you know, I always knew I would [inaudible] and was always aware that there was a need for families to be given care."

Grace had recognised the need for family care but had found this difficult to provide in an NHS context:

AS "... do you remember when the idea first occurred to you that you'd quite like to do this sort of work?"

GE "Gosh - Yes [SP] some years ago [SP] maybe ten [SP] maybe ten years ago, you know [SP] there'd be I think there were probably a couple of occasions where, you know, it really did hit home you really wanted to spend time with relatives, cos they needed you [SP] and the patients as well, but you just couldn't give them the time."

Environment/working conditions

Eleven respondents referred to features of the hospice environment which may have encouraged them to enter hospice nursing or to remain in that environment having made the move.

Stella had been attracted partly by the "beautiful surroundings" of the hospice, which contrasted markedly with those of the general hospital in which she had been working:

"I'd been working for 12 years in the general hospital which [SP] I mean, you know what they're like, where comfort isn't the [SP] the whole [SP] the whole purpose. It's quick [SP] get that patient better, get them out of the bed and put the next one in the bed. So, you know, the beautiful surroundings, the [SP] just having more time to be with people, rather than rushing to do stuff and get on to the next patient - just having time to be with people and just valuing [SP] I suppose valuing my colleagues and valuing patients and families as people - not just as somebody in the bed to be sorted out and moved on."

Catrina spoke of the "ethos of care" of which she was aware in the hospice she worked in:

"... ward nurses are not caring, but here, there's definitely that huge ethos of care, and that's just in the whole atmosphere, and I think [SP] like you were saying, a lot of people have said this is what proper nursing is. I think it refreshes the nurses who work here, so they actually want to come in. Like I'm someone who said I'd never do shift work again - I actually look forward [SP] I have to wake up at [SP] I actually live quite far from here, and I've got the motivation to travel an hour and fifteen minutes to get here to work, and the times don't bother me [SP] just cos [SP] I'm quite happy to come in to work."

Support for nurses

Several of the nurses had found the level of support offered to hospice nurses an attraction:

"... when I looked after my mother and then I moved directly to look after my father [?] I always felt [SP] I mean they had palliative care to the highest degree, being in their own home [SP]. I mean,

what better way to die than with your whole family around you? And I was [SP] I wanted to give that to other people, um, so this is the place *I* can do it [SP] I mean, I could go on [SP] into the community and do it but I need the support of the team [SP]. I'm not very good at working on my own, and I think it's the team that keeps you going, because the goodwill that's on the ward is unbelievable... "

(Angela)

Religious beliefs

A small number of respondents indicated at interview either that their religious beliefs had played a part in bringing them to work in a hospice setting or that they were pleased to be able to talk to patients about religion when they showed interest in talking about such matters.

Jonathan, who had obtained a degree in theology before training as a nurse, had sought out hospice work as a setting in which he could put his religious drive to best use:

"... I was just looking through um web sites for things mixed a little bit with the sort of the Christianity side of me [SP] the desire to try and fulfil that higher duty - um, get out there and sort of look after the sheep and stuff and do unto others as you would do for Jesus, sort of thing... This hospice came up [SP] thought that'd be a great way to come in [SP] look after people who are dying..."

Steffie felt that her Catholic background had probably made her aware of the importance of palliative care:

AS "Would you say there were any particular beliefs or values that have guided you in your life?"

SZ "I think my Catholic upbringing probably has guided me a lot, and I think that has a lot to do with why I think palliative care is very important, especially now, at the moment. Not that I'm against it or would consider it, but the euthanasia laws and regulations that are going through, all the bills

that are being discussed at the moment, that has a lot of [SP] for me, and a lot of, I guess, religious sort of context to it, so I guess that would have influence on [SP] on the way that I'm working..."

In response to the checklist, respondents were more likely to rate "spiritual/religious beliefs" as having had a strong influence on their choice of hospice nursing than to say this about their original choice of nursing (15: 52% as against 10:34%). (See Chapter 11 for a discussion.)

Multidisciplinary working

Gordon felt that hospices provided a better opportunity for multidisciplinary working than other areas of nursing:

GW "... There's much more working as a multidisciplinary team. The relationship between the nurses and doctors are [SP] is much more on an equal basis, or much more on a better working relationship, often, so, you know, it's that sort of thing that, um, enables you to work better..."

Lack of staff hierarchy

Catrina, who had disliked the rigid hierarchies she had encountered during her training, had liked the fact that such hierarchies did not exist to the same extent in hospices:

AS "... was there anything about hospice work that attracted you to it?"

CA "Yes, definitely - so many things... there's the hierarchy in other places where you work, but you don't feel that hierarchy working here at all - not at all... There's always someone that I can talk to and things, so that's very nice."

Nurse-patient relationships

Although it was not often identified specifically as having attracted nurses to work in hospice nursing, the development of nurse-patient relationships featured as an important factor in responses to the checklist nurses completed after interview. Those who returned a completed

checklist were much more likely to rate 'Relationship with patients' highly as a factor in their choice of hospice nursing than to say this about their original choice of nursing (18:62% as against 10:34%). (See Appendix 8.)

Diane felt that what was attractive in the opportunity hospices offered nurses to give 'basic nursing care' was not the tasks themselves, but the opportunity these tasks gave for the development of close nurse-patient relationships:

AS "And do you see hospice nurses as being different in any way from nurses working in other specialties?"

DL "... they tend to want to be at the bedside - they do tend to want to do the basic care. Um, which [SP] you know, people say 'Oh, that's what nursing's all about, doing the basic care' by which they mean washing people, dressing them, feeding them, taking them to the toilet, doing their dressings and being with them for a long time in the day, which is actually very boring and very tedious work if [SP] if [SP] if you didn't engage with the person. So I really think it's the contact with the people that they enjoy. Cos you can have a wonderful experience bathing a person - just wonderful - or doing their dressing, even though the dressing might be foul, but that kind of level of contact that you have with the person is like no other..."

Psychological factors/aims and desires

Several respondents suggested psychologically-based reasons why nurses might choose to work in hospice nursing.

Alison suggested that some people seeking to work in this area of nursing might be looking for bereavement support for personal losses they had suffered:

"Some people do approach us from the point of [SP] like yourself, they've had previous bereavements, and in a way want to sort pay us back somehow, you know, for the support they've

had, but I have to be very careful with these [SP] that particular sort of group [SP] to really establish what it is they're wanting [SP] whether it really is bereavement support they're wanting, or is it really because it's the area of work that they want to work in? Um, and if you don't sort that out at an early stage, it can become [SP] you know, you can cause conflict within that person."

Stella also suggested that some nurses applying to do hospice nursing were seeking to meet a personal psychological need:

"I think you have to be pretty tough and pretty sorted out emotionally yourself [to do this work]. I think you have to be quite strong, because what you're meeting is other people's distress and crisis and I think if you yourself are not in a good place, you can't possibly help those people because you're so emotionally churned up. However, my personal feeling and, you know, just from observation, is that there are an awful lot of people in palliative care who are in exactly that state - they're in palliative care because it's [SP] it's meeting a need in them [SP] what's lacking in them [SP] and the danger for them is that they burn out. I think you have to be very [SP] have very strong boundaries about what is caring in a professional way and caring in a personal way."

The most frequently expressed factor in terms of aims and desires was a wish to "make a difference".

Grace felt that, in hospice work, she had found what she had come into the work to do:

"... I do feel [SP] you know, I found what I came into the job to do, and that was to make a difference... to make somebody's [SP] you know, to give somebody a good death, if that doesn't [SP] you know, to make sure that people are pain-free, and not feeling sick, um [SP] and scared [SP] you know, I hate the thought that somebody's scared..."

A "wish to provide high quality care" and "personal beliefs and values" were both highly rated by those respondents who returned a completed checklist. In both cases, 24 (83%) rated these items '4' or '5' (see Appendix 8).

Personal experience of death and illness

Several respondents indicated that their experience of death or the illness of other people had been a factor in bringing them to work in a hospice. Diane observed:

"... the groups I've worked with tend to be people who, um, have perhaps got a personal [SP] had some personal experience that has made them want to do it."

Patricia felt that the sudden death of her mother while on a foreign holiday might have had some influence in leading her into hospice work:

AS "Do you think any of your own experiences in life have had any impact on your decision to do nursing or palliative care?"

"... I've often wondered whether the unfortunate circumstances around my mum's death somehow led me here. But I don't know. Maybe it's just that urge to put things right and do [SP] you know, because I've got this strong sense of doing it right and doing it right first time and only having that chance to; maybe that comes back from the fact that my mum went so quickly..."

Several respondents identified caring roles which they had adopted as adults as having influenced them to work in hospice care. Carol had helped to care for a friend/ex-colleague:

"... before I started the nursing course [SP] I did help to look after a friend and ex-colleague who was dying of cancer, and that was one of the things that interested me in terminal [SP] well, in hospice care, terminal care. He didn't go into [SP] he died at home but I helped his wife look after him... So that was kind of a big influence on [SP] not doing nursing per se, cos I was already going to do it, but what direction I might go in afterwards."

Those who returned a completed checklist were much more likely to indicate that experience of death or loss had influenced them strongly in the choice of hospice nursing than to say this about their original choice of nursing (12: 41% as against 5:17%) (see Appendix 8).

Intellectual interest in hospice/palliative care

A small number of respondents reflected on the attraction that hospice work had held for them intellectually. It had been Matthew's interest in the psychosocial aspects of care which had drawn him towards this work:

AS "Was there anything in the training that would have pushed you towards doing palliative care work?"

MB "No... The first time I thought about it, was [SP] it was through my interest in the psychological dimensions - both health care and health care workers - that I came across death and dying in the work of people like Kubler-Ross. Remember that in the seventies, that wasn't really well established - the first hospice [SP] modern hospice, St Christopher's, only opened in '67. So it wasn't much talked about, or even known about."

Matthew saw his interest in psychosocial aspects of care as being related to features of his own psychological makeup:

MB "... I suppose central to it is this sense of caring for others. I'm not a particularly social individual - I'm not particularly easy in social environments, so it's a bit odd that [SP] you know one of my themes is obviously communication, as part of the psychosocial dimensions of care. But it's more from recognising in myself the difficulties that I have with that that have interested me in the subject and enabled me to tackle it in a professional sense, I think."

From several years of study, Carol had developed an interest in issues relating to continuity of care, and who did or did not get palliative care and how palliative care is defined. She had been particularly attracted to hospice work by its innovative nature:

AS "Was there anything in particular about hospice work that attracted you to it?"

CE "Well, initially it was because I didn't think this sort of work was going on anywhere else, and that was true in the eighties, it really wasn't. You know, it was a very [SP] I see now with hindsight

how undeveloped it was, actually, really undeveloped... you know, over the 25 years or whatever it is since I first worked in hospice, of course, things have moved on hugely and palliative care is much more part of the mainstream."

Literature on palliative care

Three of the nurses said that they had been influenced by reading about hospices. Mark recalled the powerful effect of a book he had read while working abroad. A girlfriend who lived in the nearest town had brought him copies of a newspaper in which a book on hospice care had been serialised:

"... she and I shared a post box, and she brought my post down, cos I couldn't get through this [SP] the muddy [SP] the roads were just washed away but the motorbike could go most places and... she came down and she brought with her three copies of the international version of *The Guardian* which I was subscribing to, and in there was a serialisation of a book called *A Way to Die*... In that book [Victor and Rosemary Zorza] describe how their daughter... died. And how difficult it was, obviously, with a 20-year-old girl but how they discovered right at the very end of Jane's life [SP] hospice... and how well she died there, and what a fantastic thing this was, and why weren't there more of these places...? And it really struck a chord with me, and I thought, then, 'Maybe I should go into hospice work'."

Pragmatic factors

A small number of respondents indicated either that they had themselves had pragmatic reasons for choosing to work in hospice nursing or that they felt other nurses might have such reasons for doing so.

It did not seem that pay-differentials between hospice and NHS specialties were an incentive to choose hospice work. Susan said that salaries in hospices were the same as those within the NHS:

"[It's] no different... There isn't any pay-driven reason for doing this."

Convenience had been an issue for Carol, who had called in to her local hospice on spec and been successful in securing a job:

"I knew of this place [SP] I mean I'd heard of it before, when I was at _____as a student nurse... while I'd been away, it actually changed into this modern - well I mean, it's not modern now - but the new idea of a hospice and I knew it existed and it was convenient for me, so I just came on spec and was interviewed and was given the job. So that was me for the next two and a bit years."

Janet felt that some of the nurses who had been working in hospices for some time may have come into it seeing it as ' just a job ':

"I think some of... the nurses who tend to do nights a lot, um [SP] some of those [SP] like some of the women who maybe come from the West Indies - they've come to do this [SP] they came to do it and they took it as a job. So I think maybe there was [SP] I mean, it sounds awful to say, but maybe less dysfunctional than some of the people who've gone into it because they really [SP] you know, really need to care for other people."

Several of the nurses drew attention to the fact that, with cutbacks in the NHS, nursing jobs were not as easy to obtain as they had once been, and suggested that this could be one reason why more recently-qualified nurses were now seeking hospice jobs.

Mark commented:

"[We're] now having applications from people who've just completed their training, and I think they're applying here not from any great vocational sense, but from the need to get a job, which is fair enough. Because they can't get jobs in trusts which are in such dire financial straits."

'Accident' or 'chance'

Three respondents attributed the fact that they had come to work in a hospice partly to 'accident' or 'chance'.

Alison said that her entry into hospice work had not been "premeditated" or "planned":

"Um, why did I go into it? Well...I fell by default, I suppose."...

AS "What was it brought you [SP] what was your thinking process that brought you to apply for the job here?"

AM "I really can't tell you, except I found an advert in the local... press... and there was a little advert in the corner of a page, and I just happened to be reading it one day and I saw this thing and I thought 'Two nights a week - that'd be really sensible [SP] really nice...' And to be honest, I applied thinking, Ann, that I wouldn't have a hope in chance of getting it, to be really honest with you. And at that stage I thought 'Well, give it a whirl - just see what happens.' And that is literally how it happened. It wasn't premeditated, it wasn't planned, it wasn't something I had a burning desire at that time to do, but I certainly knew on the day of interview it was going to be where I wanted to be."...

"... I just fell into it [inaudible]. It was nothing to do with the fact that I experienced death in the family or lost a friend..."

Chapter summary

The nurses' recollections of their years of training suggest that during those years they had developed clear personal ideals of nursing care and identified core values by which to rate quality of nursing care. Positive and negative role models, hospice placements and 'good' and 'bad' experiences of death all helped the nurses to refine their 'being-towards care'.

By the time they had emerged from training, some of the nurses had begun to assume a 'hospice nurse identity'. Others had worked in other specialties in a search for congruence between working environment and their 'being-towards-care', which had brought their ideals face-to-face with the realities of nursing in the 21st-century NHS. Having established a general identity as a 'nurse', the nurses were now beginning to identify more clearly with a particular *type* of nursing.

In the following two chapters, I move on to examine the ways in which respondents talked about their experiences of 'being' a hospice nurse and how they identified the nature of hospice nursing. In Chapter 9, I look at how they conceptualised hospice care, focusing specifically on the ways in which it was seen as different from NHS acute care.

Chapter 9: Finding meaning in nursing

In the previous three chapters, I have examined the ways in which the hospice nurses talked about the process by which they had first of all become nurses and then chosen to nurse in a hospice. In this chapter, I look at the ways in which the nurses perceived hospice care, focusing on the contrasts between NHS nursing and hospice nursing which emerged as a strong theme from the interviews.

A central theme emerging from the analysis of the interview data is what I have chosen to refer to as 'dichotomous perception'. Although there were only two questions in my interview guide which directly addressed the issue of differences between working in a hospice and working in other specialties (see Appendix 6) a marked feature of the interview data was the drawing of contrasts between the nurses' experiences of training and working in NHS hospital or community settings and their experiences of nursing in a hospice environment. The nurses frequently used these contrasts to identify what they saw to be essential features of hospice nursing, and from the thematic analysis of the interview data, four general facets of hospice work emerged as having meaning for the nurses in terms of the ways in which they perceived hospice work and vocalised their preferences for working in hospice settings: attitudes to death, working conditions for nurses, the nature and quality of nursing and patient experiences of care. An examination of each of these aspects of hospice care will help in our search for understanding of the nurses' perceptions of what it means to 'be' a hospice nurse.

Attitudes to death

While NHS hospitals were seen by the nurses as focusing on restoring patients to health and as treating death as 'taboo', hospices were seen as having an accepting openness towards issues around death and dying.

Marion had noticed, while working in a hospital setting, that some nurses were not comfortable dealing with dying patients:

"I think you have to want to nurse the terminally ill and be able to deal with death, so it's not a nursing environment for everybody, definitely, and I think when I worked in the acute hospital I saw that some nurses were uneasy around patients who were dying - they definitely preferred looking after the living."

Felicity remembered being aware of the openness with which hospice staff talked about death when she had moved into a hospice environment from a hospital setting:

AS "... was there anything in particular about hospice work that attracted you to it?"

FY "... I think the openness. I think when I first came here from the hospital that people actually mentioned death and, you know, that the patient was dying. Most of the patients [SP] actually their relatives [SP] that was amazing, because in hospitals you don't say that - or you didn't say that [SP]. 'They're unwell ', 'They're poorly', that's what you'd say. And to actually sit and have a frank discussion with somebody that [SP] you know, about their last days, and things, was just amazing."...

"You have to play it very much by them and what they can accept and listen to and understand, and you may have to go back several times, and it may be at a very inopportune moment, like you could be wiping their bum or something when they ask you the question, and you need to judge it by that [SP] not have interruptions so you get called away [inaudible] or to make yourself have interruptions, cos sometimes it's like 'I don't want to [SP] I can't answer that question, so I'm just going to divert their attention somewhere else.' If you can't talk about those sorts of things here, then where can you talk about them?"

For Christine, differences in attitudes towards death and dying between hospitals and hospice represented an important indicator of differences in the focus of care:

"... I suppose part of [how palliative care work differs from work in other specialties] is accepting that we can't do everything, we can't save everybody and that, um, the illness the patient has is going to take its course - nature's going to take its course... [In hospitals when patients were

resuscitated] it never worked, the patient would die a very undignified death with [tubes? wires?] sticking out of them... And in this environment, um, we have the odd person who will choose to be for resuscitation, um, but generally, everybody knows what the end of the story will be sooner or later, and [inaudible] you don't try to deny that."

Working conditions for nurses

General environment: 'Hospice is a nice environment to work in'

Several of the nurses referred to their appreciation of their working "environment" or the "ambience" of the hospice in which they worked. For Stella, there had been a marked contrast between the hospital in which she had worked previously and the "beautiful surroundings" of the hospice in which she was subsequently employed.

Marina was also aware of the contrast between the hospital environments in which she had undertaken her training and the level of equipment provided in the hospice in which she was now working:

"... it is the reality of nursing... not enough time, and not enough stock, searching for hours for hoists, whereas here you don't have that... it's just so well-equipped."

Felicity had first been impressed by the general hospice environment when visiting her uncle in one:

"[I] thought 'Wow, this is a really nice environment to work in."

In particular, Felicity had noticed that the environment was "very relaxed."

Staffing levels/balance: 'Hospices have better staff:patient ratios and more qualified nurses'

Twelve of the nurses referred to the fact that hospices had better staffing levels than general NHS hospital wards, with some linking this directly with the higher level of patient care this facilitated.

For Marina, improved nurse: patient ratios represented one of the distinguishing features of hospice care:

"... I think [time] is the biggest thing... and the nurse to patient ratios as well. They're like one nurse to three patients."

These staffing levels contrasted sharply with the situation Marina remembered having experienced on a cardiac unit where inadequate staffing levels had, she remembered, put patients at risk:

"... one nurse to eight patients was [SP] wasn't safe, it wasn't safe..."

Jenny recalled having appreciated the higher staffing levels she encountered when she had come to work in a hospice after running a nursing home:

"I enjoyed, um, the fact that we had a high nurse to patient ratio, and so you were doing things well, and you felt at the end of the morning, as I feel at the end of this morning, that we've managed the patients really well, they've had good care, good symptom control, and I'm not, um, ashamed of anything - it's all good [SP] good work... Just sort of reassured that, um, that you couldn't do any more for them."

Could it be the case that higher staff: patient ratios are attractive in their own right, so that nurses might be equally attracted to any nursing specialty which offered good staffing levels (or, indeed, to private nursing) regardless of the patient group? Barbara was clear that higher staffing levels alone would not have been sufficiently attractive to have drawn her to work in any other specialty:

AS "And was there anything in particular about the hospice setting or hospice work generally that attracted you to it?"

BU "It is the nurse to patient ratio, definitely."

AS "So, if you had that same ratio, say on a paediatric ward [SP] was it more that you were able to give the care you wanted to, regardless of the patient group [SP]?"

BU "Oh, I think the patient group is the most important thing, yes. So no, even if I'd have known [SP] had that sort of ratio on a different ward, no, I wouldn't have [SP] it's the patient group."

The issue of 'staff balance' (in terms of the ratio of qualified nurses to health care assistants) was also raised by a number of respondents, with reference to the fact that this ratio tended to be higher in hospices than in NHS hospital settings:

"... trained nurses within hospitals, they're usually managing the ward, so they're taken away from patients completely and it's the untrained nurses who are often the ones who are providing care. Whereas here... it's a high trained nurse ratio - as a trained nurse you can provide care."

AS "And do you have untrained nurses here? Do you have health care assistants?

SC "Yes, but it's not as many as you would find on a general ward. We have a high trained nurse ratio."

AS "What sort of proportion would that be?"

SC "I'd probably say two thirds are trained nurses and a third are untrained."

AS "And in a hospital, it would be the other way round?"

SC "Absolutely."

(Susan)

Emotional and psychological support: 'Hospice nurses are well supported'

In Chapter 8 Jonathan recalled his experiences of lack of support by colleagues and superiors while working in an intensive care unit. Nurses who frequently experience the death of patients they have cared for may be in particular need of emotional and psychological support, and it was clear from the interviews that hospices were perceived as particularly good at offering this kind of support.

Steffie, who had worked on a gerontology/oncology ward in Australia after completing her nurse training there, remembered it as having been particularly supportive of the nursing staff and felt that hospices needed to offer high levels of support to nurses because of the demands made on them:

"... it seemed to be more supportive than the other environments that I'd worked in."

AS "That's interesting, because that has actually come out [SP] quite a lot of the people I've spoken to, when I've asked them what it is about palliative care that they like, that's one of the things they pull out, and say you get so much more support here than you do in other specialties."

SZ "Yes, I think you do. Because it is a hard area compared to [SP] basic nursing. [SP] It's not [SP] it's not just a basic nursing skill. I think it's something that you sort of have to experience."

Hazel had been impressed, when she had been interviewed for a position at her current hospice, by the way in which she had been asked how she felt about her father's death:

"And bear in mind, that was probably about 20 or 30 years afterwards by that time, and I could just see how brilliant they were at [SP] not exactly bereavement counselling, but bringing you out to talk about things that you probably hadn't felt like talking about or been able to talk about before..."

Barbara related an incident which illustrated the sensitivity and supportiveness hospice nurses showed to their colleagues:

"[While I was here as a student] we had a chap who had a brain tumour and deteriorated quite quickly and was getting quite aggressive and they had to give him something to sedate him, and he had the fear in his eyes and I just found that so horrible and ____picked up on it: 'You don't need to be here, Barbara.' You know, 'Come on, go and have a cup of tea.' And when he died, I was off [SP] I wasn't on duty and I came on and his room [SP] as I walked past his room was empty and as soon as I walked to the nurses' station, they just knew. 'Oh, come on and come [SP]' and they took me down to the mortuary to say goodbye to him. I mean, that might sound a bit strange to some people, but [SP] and that is the way people are here."

Stress: 'Hospice nursing is less stressful'

Levels of perceived stress in any given nursing environment might be seen to be related in part to the adequacy of staffing levels in that environment.

Susan was quite clear that, at least for her, stress in hospice care did not arise from the fact that patients often died but from inability to provide optimum care :

"... if nurses in palliative care feel that they're not giving optimum care, it can cause a lot of stress. And I don't think it's around death and dying. I think the stresses are around whether they feel they're providing appropriate and adequate care... For me, [caring for dying people] doesn't cause me stress, by people dying. What causes stress is when I'm not providing what they require to die in the way they want to die."

Christine also referred to the fact that "stress" could result from lack of satisfaction with the level of quality of care nurses were able to provide. She had liked the idea of working "in a place where there is a little bit less stress" which she said had been an attraction of hospice work:

"You sometimes get extremely busy, and everything, and you have lots of stress, but um, when I think back to the acute hospitals, you know, the stress of working there, and the stress of not being satisfied with what you're doing is the thing. The more I look back on it and some of the conditions I was put in... I don't want to do that any more."

Power and status: 'Hospice nurses have more equality with doctors and greater autonomy'

The theme of relationships between nurses and doctors emerged strongly from the interview data, with contrasts being drawn between hospital doctors (who were seen as sometimes being rude, arrogant, unaware of patients as people and 'superior' in their attitudes towards nurses) and the doctors working in hospices (who were perceived as approachable to patients and nurses alike, receptive to the views of all levels of staff and willing to treat nurses as equals).

Stella referred to surgeons who "think they're God" and provided a contrasting image of a consultant at her hospice, whose "way of being" was "just poles apart... absolutely poles apart".

Susan drew an interesting distinction between a hospice in which she had worked previously and the one in which she currently worked in terms of the effects of the doctor-nurse staffing balance on nurses' feelings of confidence:

"I think that nurses on _____ - because there was less medics - the nurses were much more confident and skilled, because they had to be, and they had to be much more proficient at making decisions. Whereas here, because there's much more of a medical presence here, the nurses, I don't think probably have [SP] their decision-making ability is probably not at that high a level, as would be if there was less doctors around, so the nurses turn to the doctors much more quickly to make decisions than they would if they weren't present."

Gordon felt that feelings of equality of status with medical staff allowed nurses in hospices to "work better":

"The relationship between the nurses and doctors are [SP] is much more on an equal basis, or much more on a better working relationship often, you know, it's that sort of thing that, um, enables you to work better."

Janet had "hated a lot of the hierarchy" she had encountered in hospitals but found that in the hospice, "doctors were really respectful and really listened to your opinion. And it really felt like we were working as a team."

Catrina also felt that nurses' opinions were valued more in the hospice environment than in an NHS hospital:

"... nurses' opinions are valued so much more and they're actually taken on board as well and it's not even [SP] it's just the whole team - it's not even by doctors - everyone values the nurses a lot more. And you're also - I don't know, there's the hierarchy in other places where you work, but you don't feel that hierarchy working here at all - not at all."

In talking about their status and autonomy, the hospice nurses frequently focused on their role in drug administration as illustrative of their levels of freedom to act in the best interests of patients. Contrasts were drawn between the rigidity of drug administration in hospitals (where nurses had little latitude in the administration of drugs to control patients' pain and where nurses always had to ask a second qualified nurse to check their drug administration) and drug administration in hospices (where doctors would prescribe a range of drug-dosage, leaving nurses to adjust the amount of drug given to individual patient needs and where it was not necessary for nurses to find a 'checker' to ensure that they were giving drugs correctly).

Marion felt that having freedom to administer drugs within prescribed limits and not having to seek a 'checker' nurse meant that hospice nurses were able to "look after your patients better" and respond to the need for pain-relief much more quickly:

"... you can look and see what the doctor has written for [the patient] to be prescribed as [the patient needs] it and do it, and [the patient will] get it within five minutes."

Marina described the way in which hospice nurses were able and expected to make fine judgments about drug dosages:

"... with things like syringe drivers, [the doctors] write from say five to a hundred milligrams so you could [SP] you have to make a decision about how agitated the person about how much [inaudible] you're going to give them because if they're extremely agitated you'd be close to the hundred. [SP] If they just [SP] if they seem relaxed [inaudible] that you just want to keep them comfortable you just give them about five, so there's a lot of rein that you don't have to go to doctors and say "Oh, excuse me, can you say if what I'm doing is right?"

Autonomy in drug administration clearly depends on sensitivity to and awareness of individual patient need, in that nurses can only make fine adjustments to drug dosages if they have developed a close enough relationship with the patient for them to understand or interpret their varying needs. Marina commented on the fact that hospice nurses' autonomy in drug administration increased their morale and by linking this autonomy with awareness of individual need, suggested that close nurse-patient relationships were an integral part of the morale-boosting effect:

"... I think [the autonomy] increases morale, really in the team, that [SP] because you do know your patients [SP] like you could see your patient one day, and then the next day, and you'd know if there was a difference. Whereas a doctor sees them from time to time, and even if you sort of notice that they're more agitated than they'd been so you can sort of say "Oh, they're a bit [inaudible]' and do it sooner rather than later so they maintain being comfortable..."

Job satisfaction: 'Hospice work gives nurses a lot of job satisfaction'

Several of the nurses contrasted working in NHS hospital settings (where work could be frustrating because of inadequate staffing levels and equipment and where job satisfaction was hard to find) with working in a hospice setting (where, because it was possible to provide 'good' nursing care, job satisfaction was more readily attainable).

Matthew, who recalled having to "run around non-stop for 12 hours and yet know that you hadn't met the needs of your patients or the relatives" in a hospital setting said that, in such conditions, nurses "didn't even get any job satisfaction".

Marion, who had worked as a nursing auxiliary in a hospice before entering nurse training, and who had "tried to keep an open mind" on the specialty in which she would work once qualified, had obtained no job satisfaction in hospitals:

"I tried to keep an open mind, but I think that nursing on general wards in acute hospitals didn't leave me feeling satisfied - in fact it was quite the reverse; it left me feeling very frustrated and dissatisfied, because I'd go off duty some days wondering what I'd actually done for anybody..."

Barbara felt able to provide "holistic care" in a hospice setting and had chosen to work there partly because she had felt that she would not have been able to enjoy working in a hospital setting:

"... I think, for me, if I'd have got a job working in the acute sector, I think I would have just been so frustrated and unhappy. So I would have gone home every day thinking 'I haven't given the care that I want to give to my patients'."

Time available to care for patients: 'Hospice nurses have time for their patients'

The concept of 'time ' emerged as a very strong and multi-faceted dimension of hospice nursing in the nurses' narratives. Contrasts were frequently drawn between hospital settings, in which there was not enough time to enable nurses to provide the level and quality of patient care they wished to provide, and hospice settings, in which time was a resource which could be freely drawn upon to allow nurses to care in ways they could accept as representing 'good' patient care.

Time was seen as lacking in hospitals because of inadequacies of funding which led to low staffing levels, poor standards of care and a 'task-orientation' in which a focus on 'getting jobs done' meant that spending time talking to patients and getting to know them was not valued. In hospices, on the

other hand, higher levels of funding meant that staffing levels were higher, and this combined with an orientation towards 'care' rather than 'cure' to produce a situation in which nurses were expected and encouraged to 'spend time' with patients.

The ways in which the nurses talked about 'having time' is dealt with more fully in Chapter 10 as an important feature of 'being a hospice nurse'.

Nature and quality of nursing

Opportunities to provide 'good' nursing care: 'Hospices provide high-quality nursing care'

The ability of hospice nurses to provide high quality patient care - care which met their 'ideals' of good care - emerged as a very strong theme from the interviews and was very highly rated as an influencing factor in choice of hospice nursing by those who returned completed checklists (see Appendix 8). The ways in which nurses described their aspirations for the provision of 'good patient care' and how they perceived this (in terms, for instance, of the standards of care they felt able to give in hospices, the 'holistic' nature of 'good patient care' and the distinction between 'hands-on', 'basic' or 'bedside' nursing and other nursing tasks) is dealt with in greater detail in Chapter 10. In this chapter I look more generally at the ways in which the nurses differentiated between the nature and quality of nursing in acute hospital settings and in hospices.

'Care' versus 'cure': 'Hospices focus on "care" not "cure"'

The nurses frequently drew distinctions between the 'curative' aim of acute hospital nursing care on the one hand and the 'caring' aim of hospice care on the other. Two of the nurses explicitly referred to the fact that the concept of nursing is frequently linked with the aim of restoring patients to health:

"I suppose people think of [SP] In general, I suppose people think of nurses as people who make people better, don't they?"

(Alice)

"... not many nurses come in to this [SP] like, you say, nursing and like doctors and things, you're meant to cure people and you're meant to get them home and things, but this [SP] this side of it is just as important, if not more."

(Catrina)

Jenny observed that hospice care differed from acute hospital care in that patients were not expected to recover, and related an episode in which she had drawn on this difference, in a humorous way, to explain her role to some neighbours:

"It is different, isn't it, because your patient isn't getting better... When I moved into this house and the neighbours realised I was a nurse, they started coming round and saying 'Can you tell me about this?' And 'They've told me I've got that, and what do you think?' And I just looked at them one day and said 'Do you know, all my patients die?' [shared laughter] They didn't come any more after that. But that's the difference, isn't it?"

Alison drew a distinction between the care provided in accident and emergency departments and the care provided in the hospice:

" A and E, you're actively trying to make somebody better, whereas we are actively helping somebody to die peacefully and with dignity."

For Matthew, hospice nursing care (and, indeed, nursing care in general) was concerned more with "caring" than it was with "treatment":

"... my understanding of the nature of nursing... is - it's very hard to pin down - but to put it very succinctly, it's about caring more than it is about treatment...the concept of diagnosis and treatment takes a bit of a back stage. It's in the background, and it's essential to all that's going on but it's not your first focus, because your first focus is this concept of caring for the whole individual."

Grace provided an example of the way in which patients with similar symptoms might be treated differently depending on whether they were seen as requiring acute or palliative care:

"... within medicine, you're intervening all the time if somebody becomes acutely ill, whereas here, you have to learn to take a step back, whereas if somebody became acutely short of breath in a medical environment you'd be putting oxygen on and various drugs to help them, whereas here, you sort of have to take a step back and you don't sort of rush in and do too many acute things. I thought I might find that difficult, but it's [SP] that's not been [SP] no [SP] I've sort of got my head around that. I don't think, you know, I should be intervening all the time and giving acute things, which is what I was used to.

Caring for the whole patient: 'Hospices provide holistic care'

The provision of 'holistic' nursing care which represents an ideal in nurse training and which it was possible to provide in hospices was frequently contrasted with the more focused 'condition-oriented' nursing which nurses were expected to provide on acute hospital wards. This issue is dealt with in detail in Chapter 10, as it appeared to represent for the nurses a central defining feature of hospice nursing care.

'Hands-on'/'basic'/'bedside' nursing versus management/administration/paperwork: 'Hospice nurses can do "real" nursing'

The nurses frequently referred to the fact that, as hospice nurses, they were able and expected to provide nursing care which they variously described as 'hands-on', 'basic' or 'bedside' nursing. Contrasts were drawn with the situation in hospitals, where this level of nursing care tended to be provided by health care assistants (with qualified nurses being 'taken away' by other tasks). This distinction is dealt with more fully in Chapter 10.

Level of technological input: 'Hospice care is "low-tech" care'

A small number of nurses distinguished between the 'hi-tech' nature of acute hospital care and the 'low-tech' approach of hospices. Susan observed:

"I think the technology's not here. All that technology that you find in hospitals, nurses having to do all those high-tech bits - interventions. We don't do observations. We don't have to do those. You don't have to fill in all the fluid charts."...

"You can be with the patient whereas in hospitals, you're a lot of the time taken away because you're doing all this technology."

Carol was much more interested in communication with patients than in "high-tech" nursing, which she felt gave nursing a lot of "kudos":

"... I'm much more interested in the care and communication side than I am about being, you know, the kind of high-tech wizard and managing to do all these things that actually give nursing quite a lot of kudos, I think, and medicine also, because surgeons are very highly regarded, aren't they, and that [inaudible] dexterity and technology writ really large. I wasn't interested in all that."...

"... I just thought the hospice is where people... you know, it's low-tech, you're not rushing around with, you know, CVP lines and, you know, intravenous injections and all that kind of stuff..."

In Chapter 8, Diane described the way in which "rushing around with lights flashing and trying to thump on people's chests" had "really frightened" her and Barbara also indicated that, as a "technophobe", she would not have wanted to be an "acute nurse" and that the idea of being an A & E nurse "terrifie[d]" her.

'Task' or 'patient' focus: 'Hospices focus on the needs of the patient'

Some of the nurses drew a distinction between the 'task' focus of acute hospital nursing (that is, a focus on completion of specific nursing tasks for those patients needing them) and the 'patient' focus of hospice nursing (in which there was no actual or theoretical list of tasks which must be completed and where individual patient need was the main concern).

Graham recalled that his experience of acute hospital care had been of the requirement to complete tasks which might be undertaken by anyone:

"... a lot of the experiences I'd had, they were quite task orientated and they were [SP] I don't know [SP] it just didn't really feel that they were [SP] it wasn't a specific nursing role [SP] it just felt like anybody could, you know... you could just give someone a list and say 'Do these things' and actually there was no... creativity, um, and you know, I just felt [SP] I just felt I would have been very frustrated working there."

Mary, who had returned to nursing after a long break, had found it difficult to move away from a focus on tidiness and orderliness towards a recognition that patients' own priorities should be nurses' first concern:

"... I frequently find when I come on duty, oh, the mess around the beds, it's just chaos! And you know, there's tissue papers on the floor and you can't find the talcum powder, and where is it? And I long to have the time to tidy up their lockers so that for the next shift, at least, they can find [SP] and there doesn't seem to be time for that. But the funny thing is, nobody else seems to worry about that - they seem to manage. So I think I'm very slowly having to learn to let go of that and, um, not to mind if you can't find [SP] the [talcum powder?] quickly.

AS "And how is it [SP] how does that affect patient care, do you think?

MT "Oh, I think it does affect patient care, because I think it's probably written all over my face [shared laughter]. I'm thinking "Oh, where's the talcum powder?"

AS "But I'm just thinking that maybe it's something to do with the change in values, because if those patients were in hospital and there were tissues on the floor and you couldn't find the talcum powder and so on, people might say that the patient care was poor, whereas here, you might say that that just shows that the values here are different - that we're focusing on people as people [SP] their whole needs and what they [SP] what is important to them."

MT "To them."

AS "So presumably, if the patient was worried about having a mess on the floor [SP]

MT "They would say [SP]"

AS "you would actually be more concerned about clearing it up."

MT "You are [SP]. You've got a great wisdom in this, Ann."

Stella contrasted the situation in acute hospital care, with its focus on the completion of a large number of 'tasks' with hospice care, in which individual patient needs received first priority:

"Rather than running around and doing a million tasks, perhaps the task you've done is to spend a couple of hours, or three hours, or a whole day [SP] the whole of your shift with one family or one person, and it's very much about everything that that person needs, for holistic focusing."

Pace of work: 'Hospice care is "slow-pace" care'

Nursing in acute hospital settings was characterised not only as "hi-tech" and "task-orientated" but also as care which had to be undertaken at a fast pace. In contrast, hospice care was seen as

taking place in a quieter, calmer environment in which nurses did not have to rush in an effort to 'get through the jobs'.

Marion had become dissatisfied with her nursing role in a hospital setting:

"I just felt it was not what I wanted. I wanted to nurse, but I didn't want to nurse in such a fast environment where [SP] I know an acute hospital is needed and necessary, for people who are really [SP] um, really ill, but..."

Alison noted that the pace at which hospice nurses worked was "much more slow" than was the case in a hospital setting, and observed that making the transition from working as a hospital nurse to working in a hospice was often difficult for nurses to make:

"... it's this transition of becoming this rush-around nurse in a hospital to a slower pace - a peaceful pace within the hospice, yes. That transition, for a lot of nurses [SP] I'm not saying all, but certainly the majority of them find it quite difficult to [SP] slow down… [but] it only takes a matter of a couple of months or so, um, to get rid of that panic and that guilt of not being able to [SP] it's more the guilt of being allowed to sit by somebody's bedside, cos they're never allowed to in hospitals, because they're just too busy..."

Angela felt that the hospice in which she worked had an air of peace and tranquillity which could be felt by people entering it:

"... people actually [come] in and [say] they [can] feel the peace... and I think that can only be the people who are working in it - how they conduct themselves. So yes, it's a peace, and a [SP] a tranquillity, I think."

Relationships with patients: 'Hospice nurses can really get to know their patients'

The hospice nurses contrasted the close relationships they were able to make with patients in the hospice with the fast-moving patient turnover of hospitals, where it had not been possible for them to really get to know patients.

Felicity liked being able to get to know patients and their relatives:

"You can nurse [SP] you can get to know your patients and [they're] not shipped in and out so quickly that you don't get to know them. You get to know your relatives..."

Christine contrasted the situation in hospice nursing (when nurses were able to follow patients through to the end of their lives) with the hospital scenario in which patients passed quickly through the system:

"... you get to see the end of the story, which is something that I really, um, like. It helps me... You know what happens in the end, you know, instead of someone coming in and they get sent off to ITU and you never see them again..."

Recalling a male nurse who had influenced him, Graham said that they had shared a "passion for the actual talking side... of the work" and appreciated:

"... the huge amount of value there was in actually spending time just talking with patients and finding out about them... Hospice care allows you much more time to do those kinds of things."

Marion enjoyed being able to get really close to dying patients in the hospice:

"... people tell you an awful lot as you get to know them - they tell you an awful lot, if either they trust you, or you're around at the right time, or they just need to tell someone."

Mary recalled that, when she had first worked as a nurse, patients had tended to stay in hospital for long periods:

"... patients stayed in bed for longer; they weren't discharged home nearly so quickly, so you were doing a lot more for the patients. Now, patients, as you know, go home after 24 hours and there's

a quicker turnover, and so you don't get to know the patients so well and you're not doing so much for them..."

Mary contrasted this situation with the hospice, where:

"... you have a real opportunity to do real, basic nursing care, where you get to know the patients and their families properly, cos they don't just tend to stay for one day and go home, so that's very satisfying. You develop a long-term relationship with a whole family."

Patient experiences of care

Dignity and respect: 'Hospice nurses can help patients have a dignified death'

In Chapter 8, Alison drew a strong contrast between the way in which patients were handled after death in hospitals (where there was a lack of respect in the handling of dead bodies) and in the hospice, where things were done "very discreetly" and bodies were moved into the mortuary fridge in "a very dignified way".

Recalling her first death experience in training, Susan said that she herself had felt "undignified and disrespectful":

"And that stuck with me, I think, all my career. And I've been nursing now for 22 years."

Jonathan linked the ability of hospice nurses to control symptoms with the facilitation of dignified death:

"I feel the job is so worthwhile. [SP] It's literally controlling symptoms and allowing people to die with dignity, um, rather than in pain somewhere in an awful state, which is unfortunately what you get in [SP] some of the NHS hospitals, just due to the lack of resources."

The concept of the 'good death' was referred to by a number of the nurses. Steffie explained what this meant to her:

"... over here [in the hospice]... you can see that what you did was correct [SP] what you did was right [SP] that that death was a [SP] what I think is a good death, whether that patient did or not, whether the family did or not. So I feel that it was a good one; that I think I've achieved what I wanted to. If I can do that extra thing that makes somebody, you know, more comfortable or, you know, happier, or look better to their partner, or something, yes. Yes, that's important to me, and I think if I can talk myself through that, that what I've done is [SP] is the right thing, or that what I've done is the best that I could do, then I think that that's [SP] sort of achieved, in a way. It helps you deal with the emotional side of things."

Preferred place of care: 'Terminally ill patients prefer hospice care'

A small number of respondents commented on the fact that patients tended to evaluate hospice care well and to compare it favourably with the care they received in acute hospital wards. Carol made an attempt to explain this preference:

"I don't think this has been researched... when relatives and patients say they like the care they get here, what is it they're actually... saying they like? And I think it's about [SP] it's not part of a big, huge, um, um, frantic hyperactive organisation; it's about coming to a place where there's a bit of peace and quiet and where people have got time. And, you know, if you've got time, then you can give empathic attention to people, and if you haven't, with the best will in the world, you can't..."

Marion had found that patients who had experienced hospice care often wanted to return to a hospice rather than go into hospital:

"... we hear [that] quite a lot. 'Don't send me to an acute hospital; I want to come back here.'"

Individualisation of care: 'Hospices care for people - not conditions'

Several of the nurses contrasted the way in which hospital patients tended to be known by their condition with the way in which hospice patients were treated as individuals.

Jonathan was clear that he preferred to deal with people rather than illnesses:

"Ultimately, I can spend time with a person, now, rather than 'bed 2', um, or 'the Ca breast' or 'the Ca lung', you know, that in an NHS ward they just [SP] they've been away from."

AS "Is that how it is, in an NHS ward?"

JP "My [SP] my experience is that people get spoken of [SP] and it happens here, still [SP] you speak about the 'person with Ca breast' or 'bed ten.' Sometimes that still happens and so you [SP] it's kind of an endemic thing, I think [SP] I think that's the right word. Because sometimes, certainly in the NHS, you haven't got the time to spend with people. You've got to deal with patients and conditions and things, which is sad."

Susan felt that hospital care was very much focused on patients' "problems":

"... in a hospital, um, the care is very focused on what the problem is and anything else about that person is not really considered. So it's very much focused on, you know, 'this patient has a fractured neck of femur', and when that's dealt with and they just say 'Right, they're going home' and nobody's even considered, often, you know, what are the real complex issues here? What's actually going on at home at the moment? What's the family structure? How are they coping with it?... I think, in the hospice environment, we provide that roundness. We consider every aspect of the patient's and the family's life and the impact of their illness on that, and so, and I think that's quite, um, quite attractive to nurses to be able to do that."

Diane offered concrete examples of the ways in which hospices do their very best to accommodate individual patient wishes:

"... it's like we've got no rules, or there shouldn't be any rules, in my view, and that if somebody wants their horse to be brought in so it can put its head in the window and they can kiss its nose, then we should arrange that."

AS "Right. Does that sort of thing happen very often?"

DL "Oh, sometimes - it has happened and, you know, we've had patients in before in the side rooms smoking joints and things, and you just turn a blind eye to it. Why not? I bloody well would, I tell you! Um and [SP] we've had all sorts of things going on. We had a patient in a room once with a rabbit that she loved in the room, and it was there for days, and our main concern was that one of us would stand on it - there was straw in the corner, and rabbit droppings, but it's what she wanted..."

Patient autonomy: 'Hospice patients are empowered'

Although the hospice nurses did not explicitly describe hospital patients as lacking power to make important decisions about their own circumstances, a number of them did refer to the fact that doctors and nurses in hospices made positive attempts to 'empower' hospice patients.

For Sandra, having control over what happened to them was especially important for patients approaching the end of their lives:

"[I believe in] the value of terminal care, and the belief that everybody should be offered this and everybody should have [SP] at least be able to... dictate the way that they're treated and the way that they get care... I know we do a lot of interventions and I know we have to rely on medical and surgical, but at the end of the day I think that the one person that does have control over their death is the patient themselves. And they should have every control over it - it's the last thing they're going to do. So why take any dignity away from them?"

Jonathan was aware of changes taking place in the general hospice environment which meant that hospices were having to become more "financially accountable", but felt that it was still possible for him to contribute to the empowerment of patients:

"... it's still a place that allows me to nurse in a manner that [SP] that gives the patient a bit more control."

Reflecting on recent developments in the design of the wards at her hospice, Felicity gave an example of one way in which attempts could be made to ensure that patients were in control of their nursing care, rather than being expected to conform to nursing routines:

"... whereas now we've just got notes in the office, hopefully it'll all be computerised and we can do it by the patient's bedside, so they'll be involved in planning their care, whereas now it's very much the nurses deciding what they want to do, so it's, you know, ' Do you want a wash now? Oh, I think you should have a wash now. OK?' They're just very small examples of that, so [SP] I think we will [SP] It's certainly the way nursing is going generally, but I think also that the [re]design of the [ward] it'll help us to be able to encourage them to sort of make their own decisions."

Family care: 'Hospices care for patients and their families'

Several of the nurses said they had been attracted to hospice work by the fact that family needs were very much taken into account by hospice staff. When she had worked in an acute hospital setting, Grace had been all too aware of terminally ill patients who "needed your time and care - as did their relatives" to whom - because of time constraints - she had not been able to give the care she would have liked to have offered.

Marion observed that caring for the family was not usually possible in a hospital situation, but stressed her own awareness of the need for hospice nurses to be available to support relatives:

"... I think that's one of the things that is so important - to give your family the time they need - we're not to be seen as being [SP] 'Oh, you look busy...' Which it is actually quite [SP] We do still get 'Oh, you look busy' and I say 'No, no, it's fine...' You [SP] you can sense sometimes... that your patient or your relative wants to ask you something. They then perceive that you're busy. 'Oh, but you're busy' and you have to say 'Oh, no, what you've got to say is important as well' and the acute sector doesn't allow, often, for that."

Marina felt that it was important for hospice nurses to be able to "empathise" with patients and their families:

"You've got to be... able to empathise with people, I think...hard as it is sometimes to sort of [SP] cos like I'm very close to my family and stuff like that, so if someone's mum's about to pass away to sort of try and get into what their son, daughter or whatever are feeling, I think you've got to think 'Well, if I was in this situation, I'd be ten times worse than they are' really, because I don't think - however long I was here - I wouldn't cope as well as some of the people that come in."

Angela explained how hospice nurses would shift their attention gradually towards the family as patients moved closer to the end of their lives:

"... I think it gets to a stage with the patient where you can't do any more reassuring or sort of nurturing cos the patient then comes into a comatose state and I often feel that the pain then changes onto the family. That's how I look on it. The patient is at peace [SP] the patient's comfortable and now the pain is here beside the bed. That's how I see it... that's really why I'm here, I think."

Chapter summary

In this chapter, we find the nurses moving towards full development of a 'hospice nurse' identity and establish the ground against which the nurses began to form this specific identity.

A very marked feature of the interviews was nurses' perceptions of contrasts between care as it was given in the NHS acute sector (which embodied their 'not selves') and care as it was given in hospices (which fulfilled their ideals and values of care and offered occupational congruence). In talking about their rejection of care which embodied their 'not selves' the nurses drew attention to the process of identification as a specific aspect of identity formation. In articulating their dichotomous perceptions, the nurses were refining and affirming their own identities as hospice nurses. Identifying in NHS care aspects which failed to satisfy their 'being-towards-care' enabled them to clarify their own 'hospice nurse' identities, in a way similar to that in which some of them had previously 'tried out' different occupational identities and later tested out different nursing specialty identities.

In the same way that they had identified occupations they 'could not' have done and nursing specialties they 'could not' work in, the nurses were now making sense of their move away from NHS nursing and into hospice work. And in articulating their negative conceptions of acute care and their positive perceptions of hospice care, they were stating not only what they could not *do* but what they could not *be*.

Chapter 10: The nature of hospice care

In this chapter, I examine five characteristics of hospice nursing which emerged strongly from the interviews as meaningful for the nurses: the provision of 'good nursing care', the opportunity to undertake 'hands-on' (or 'basic' or 'bedside') nursing, 'holistic' patient care, 'being there' (or 'being with') and the availability of 'time.' Finally in this chapter, I look at some of the recent changes the nurses had observed within hospices which appeared to represent threats to the level and type of nursing care they could provide for patients and to their identities as hospice nurses.

Hospice nurses give good nursing care

A striking and recurrent theme in the nurses' discourse was the opportunity that hospices offered for nurses to provide 'good nursing care' for patients.

Nurses cannot provide good nursing care in the NHS

The nurses frequently drew distinctions between the level and type of nursing care they were able to provide in a hospice environment and the less acceptable care provided in NHS settings.

Catrina, for whom her hospice post was her first post-qualification nursing job, had not been impressed by the nurses she had encountered during her training:

"... the nurses that I worked with in my training have been atrocious! Like really old school [SP] not even caring about patients [SP] very blasé about the whole job, and just really unkind and rude. That's what I found really off-putting."...

"... my experience of nurses on the general wards has been saying to patients 'Do you think I care? I'm only here to earn my money.' When would you ever say that?"

In the hospice, Catrina felt that nurses were much more caring:

"... ward nurses are not caring, but here, there's definitely that huge ethos of care... a lot of people have said that this is what proper nursing is."

In Chapter 8, Christine described how a community liaison nurse had intervened in an attempt to control a hospital patient's pain and said that she had "never forgotten that lady and [SP] and basically the suffering that, um, that she went through because of our ignorance." This had provided, for her, a driver towards hospice work:

"Generally, it was a mixture of wanting to provide that quality care that you aren't able to in other areas..."

Marion had been particularly aware of the way in which dying patients tended to be "[left] till last" on NHS wards, with other patients' needs being seen as "greater... in the eyes of the majority of staff" and with the ward sister giving no guidance on priorities.

Susan felt that, when she had worked on medical wards, she:

"... wasn't caring... I wasn't caring for the patients in the way that I thought I wanted to care for people. It didn't feel that I was doing nursing the way I should be."

For Gordon, hospice work had been attractive in the opportunity it had offered him to nurse in the way he wanted to:

"I think it was [SP] because I felt within the hospice field there was [SP] you were able to put into practice sort of the principles of good care much more than you could, say, on a busy NHS ward or other things, sometimes [SP] you know, the lack of time and that. I mean it's not perfect in the hospice - nowhere is perfect - but the staff ratio is often higher. There's much more working as a multidisciplinary team. The relationship between the nurses and doctors are [SP] is much more on an equal basis, or much more on a better working relationship often, so, you know, it's that sort of thing that, um, enables you to work better."

(Gordon)

Hospice nurses give high-quality care

Gordon felt that nurses in all specialties should follow the principles of "good palliative care" by which he meant:

"... good communication, support for the family, respecting people as, you know, an autonomous person - respecting them as people [SP] you know, whatever field [SP] whatever setting you're working in..."

For Matthew, working in a hospice enabled him to exercise nursing "in a way as I saw that it should have been applied in the first place" and was "looking for nursing in a purer form."

Carol said that, when she had first worked in palliative care in the 1980s, she had done so partly because she had believed that working in a hospice would teach her a lot about "caring well":

"... when I first did palliative care in the eighties, one of the things I wanted to do was to have experience of doing nursing well, and I knew then that I would in a hospice and my vague... my idea was that I would learn a lot of skills about caring well for people in a hospice that I could then use in other settings."

Grace contrasted the type of care she was able to provide in her hospice post with the administrative responsibilities which had taken her away from direct patient care when she had worked on a medical ward:

"Being a staff nurse on a medical ward, some days I'd go on and I wouldn't touch a patient, because I'd be doing paperwork or I'd be doing consultants' rounds... I used to go home at the end of the day and I thought 'Well, what have I done today?' You know, and I didn't like it. Whereas here, it's all patient orientated, and you spend a lot of time... and I do feel [SP] you know, I've found what I came into the job to do, and that was to make a difference."

Hospice nurses can give the care to which they aspire

The hospice nurses emerged from the interviews as a group of individuals who were deeply committed to providing high standards of patient care and unwilling to compromise on their nursing care.

Patricia felt that working in a hospice allowed her to do her "ideal nursing":

"... I feel I can do the nursing how I [SP] I suppose my ideal nursing..."

For Stella, hospice offered the opportunity to give care as she felt it "should be":

"I was finally tying everything together - everything came together. And I just found that [SP] the actual care [SP] the palliative care I was giving was just totally how I felt care should be."...

AS "... a message that seems to be coming through to me... is that people are doing it because they want to nurse"

SB "Yes."

AS "and they want to nurse in a way that [SP] it's like an ideal, really."

SB "Yes, absolutely."

AS "And palliative care offers that chance to do that."

SB "It does, and that [SP] that's really why I came into it, because it fitted what I felt was right, and still does fit what [SP] even though it is developing and changing..."

Grace identified in hospice nursing an ideal she had previously lost; she said that, in going to work at the hospice, she felt as if she had "refound nursing".

Susan felt that nurses working in palliative care felt "passionate" about providing good care:

"... I think the nurses who come into palliative care, um, do it because they feel passionate about providing good care and good complete, holistic care, whereas I think in the general wards, I think their time is so restricted that they forget all about the other elements that are necessary. And here, the nurses are unwilling to compromise on care; they're unwilling to give less."

Susan had sought out a setting in which she felt care was "provided in the right way that I would want any member of my family to be cared for." While she was aware that some nurses working in hospices were motivated by the gratitude of patients and relatives, she expressed a strong need to feel that she had done "the right thing":

"... I know a lot of nurses do it, probably, patients and families [SP] they get a lot of 'Thank you's and 'You're so wonderful' and 'What you've done for people has been excellent'. You know, and in some ways it's helpful to know that, because that makes you feel that the work you've done is [SP] they're grateful for that, whereas you know, that's fine to get that. But I have to myself feel that I've done the right thing."

Jenny had "loved" midwifery, partly because she had been able to provide what she regarded as good nursing care for her patients:

"... I loved midwifery... I loved it at that stage because we could do it really well, and I did it to a very high standard, and you could feel very proud of the way that you worked."

However, when working conditions had made it impossible for her to continue to provide the high standard of care to which she aspired, she had sought out an environment in which she could nurse as she wished:

"... midwifery isn't like that any more, so I knew in my heart that probably I was looking for something that I could do to a similar standard, and that's what I found in palliative care."

For Catrina, palliative nursing care represented a "gold standard" of care:

"... palliative care is seen as gold standard care, isn't it? And everywhere else is striving to match that."

For a few of the nurses, hospice nursing represented "old-fashioned care" which was recognised as a personal ideal:

"It's the old-fashioned care - you actually give the care."

(Kerry)

"... I think it's much more of the ilk and the standards that we used to have in nursing, which you don't find now in the NHS. Now I was recently a patient in one of the big London hospitals and I was very sad to see how nursing has become in those places, whereas for us here it's, um, a bit more of the standards and the old-fashioned approach which [SP] which I think everybody agrees is best but isn't facilitated in the National Health any more."

(Jenny)

Hospice nursing is what nursing is all about

Several nurses identified the nursing that was possible within hospice environments as 'what nursing is all about'. In going to work in a hospice, Matthew had been looking for "nursing in a purer form". Marina felt that hospice nursing was "what nursing is all about".

When Catrina had spent two weeks at the hospice where she was now employed, she had "really loved it":

"I thought this was what true nursing was about [SP]. You actually practise holistic care and don't just say the word, and the interdisciplinary working here as well... I really enjoyed it."...

"[Here we do] proper nursing... which is what I feel nursing should be and my other placements have disappointed me, but this is like one [SP] apart from practice nursing, this is the other one which has lived up to my expectations of what nursing should be."...

"... a lot of people have said that this is what proper nursing is. I think it refreshes the nurses who work here, so they actually want to come in."

For Emily, palliative care nursing was the type of nursing that should ideally be provided to all patients:

"... I think palliative care is very good general, sensitive nursing... every good nurse should be dealing with a patient from the top to the toe and the others around them [?], their family, their friends, their work or their needs. I view it as something that is quite simple, really. It's what good basic nursing, as taught, should be."

Hospice nurses go the extra mile

Several of the nurses described themselves or other hospice nurses as being willing to 'go the extra mile' or referred to hospice nursing as care which included attention to the 'little things' which were not dealt with in hospitals.

Hazel had high expectations of herself in her nursing role:

"... I would hope that I can just go that extra mile if necessary for people, because it's the ability to perhaps put yourself in that other person's position..."

Having become very close to one patient, Marina had been invited by the patient's family to her funeral, but she had been advised by a senior member of staff to decline:

"... we do have to go above and beyond a lot of the time, but with boundaries, really."

Marion described a situation in which "all the stops were pulled out " to help a patient achieve a special wish:

"... we had a gentleman whose daughter was getting married and it took a great deal of teamwork, but we did a very good, worthwhile, um, success, really, getting this gentleman to go to this wedding, which was in [SP] I think it was something like a hundred miles away [SP] all sorts of things that we really pulled out [SP] all the stops were pulled out to get him to go to that wedding."

Patricia saw her role as making things as "right" as possible for patients:

"... what I think of is, even though [the relatives] might not recognise it now, when they come to look back and remember the events of the death, as long as those are the positive things [SP] and, you know, any little thing can really make such a big difference to that [SP] you know, just a wrong word or, you know [SP] and I... I see my role as pulling it all together to just make it as right as we can..."

For Susan, restrictions on staff time in hospitals were likely to mean that patients' emotional and spiritual needs went unaddressed. For her, these were the "extra bit" which hospice nurses were able to provide:

"And often these are the [SP] the emotional and spiritual care [SP] is the things that go... And the physical becomes a priority and the emotional - if you provide the emotional and spiritual, then you're providing that extra bit."

Angela provided some examples of the "small things" which could be so important to patients:

"Small things matter here [SP]. Like on Saturday, a lady who died on [SP] she died on Monday morning, but on Saturday she wanted to go to the garden, so her whole bed was pushed out into the garden. OK, it was only for fifteen minutes, but it happened. Or it could be that somebody just,

you know, wanting their last bath or whatever [SP] little things that matter, whereby [sic] I'm not sure it does in all aspects of nursing. It should do."

Steffie had found that, in providing the "extra little things" for patients, hospice nurses could really get to know them:

"... you'd done all of your training to learn how to do all those [SP] you know, technical things, and you'd learnt how to do assessments of patients, and you'd learnt how to do all of those physical things to do with the patient and then to actually do all those physical things but then actually to get to know your patient really well and to do those extra little things that you wouldn't [SP] like we used to have [SP] our manager used to say to us 'If you have five minutes, ask if she wants her fingernails painted. It's always good [?] to paint people's fingernails. And you think 'I'm just painting her fingernails.' But [SP] they then start talking to you about their life, and they get to know you a bit as well and, you know, you do those extra little things that you wouldn't normally do for other people."

Good nursing depends on adequate staffing levels

The link between 'good nursing care' and the adequacy of staffing levels (which must ultimately depend upon the adequacy of resources) was articulated by a small number of the nurses.

Patricia felt that she was able to nurse in an "ideal" way when there were enough nurses on duty:

"... I've just had four or five really good shifts in a row where there's been enough staff and [SP] yes, I feel I can do the nursing how I [SP] I suppose my ideal nursing, if you like..."

Susan felt that staffing levels were important, but that the dedication of the nurses working in palliative care was also necessary for the provision of holistic care:

"I think part of it is about staffing levels, but I think the nurses who come into palliative care, um, do it because they feel passionate about providing good care and good complete holistic care..."

Hospice nurses are able to give 'hands-on' patient care

A second important element of 'being' a hospice nurse which emerged from the interviews was the provision of what the nurses referred to variously as 'hands-on' or 'basic' or 'bedside' care. Distinctions were frequently drawn between hospital settings, in which basic nursing tasks such as washing patients, giving bed-baths and taking patients to the toilet were delegated to health care assistants, and hospice settings, where qualified nurses were expected and able to undertake these tasks. It appeared that, for the nurses interviewed, these basic tasks represented 'real' nursing care and that hospital nursing was seen as 'taking nurses away' from 'real nursing' to perform other tasks such as managing wards, completing paperwork, accompanying doctors on ward rounds and administering medication.

Diane and Grace made it clear what they meant by 'basic' or 'hands-on' care:

"... washing people, dressing them, feeding them, taking them to the toilet, doing their dressings and being with them for a long time in the day... "

(Diane)

AS "And what about the hands-on elements of care? Do you actually get to do that very much?"

GE: Oh yes, I mean I've been bed bathing this morning and giving somebody a general bath and doing people's hair... "

(Grace)

For Patricia, doing 'hands-on' care was the antithesis of "doing the maths all day":

"... I feel I get the balance right, because I've done a couple of washes over the last few days [SP] you know, somebody else has taken the other responsibility from me, so it's probably a mix of

responsibilities to a point where it's perhaps fair, and the workload is [SP] is more fairly distributed between us, rather than feeling you're the one doing the maths all day..."

Hospital nurses do not give 'basic' nursing care...

A few of the nurses referred to the fact that hospital nurses gave very little 'basic' patient care:

"In the health service, the nurses [SP] the trained nurses do very, very little hands-on care, and I don't think they really know how to."

(Diane)

"You can be with the patient whereas in hospital, you're a lot of the time taken away because you're doing all this technology. And trained nurses within hospitals, they're usually managing the ward, so they're taken away from the patients completely and it's the untrained nurses who are often the ones who are providing care. Whereas here, trained nurses - cos it's a high trained nurse ratio - as a trained nurse you can provide care."

(Susan)

... but hospice nurses do

Barbara felt that the opportunity it offered nurses to provide "hands-on" nursing marked out hospice care as different from hospital care:

AS "Are there any particular things that make hospice nursing as a specialty different from other nursing specialties?"

BU "Well, I don't know if I'm answering it in the right way, but I think, for me, we get more opportunity for hands-on nursing."

AS "And is that important to you?"

BU "Mm. I think, yes, I think in [SP] you learn so much about your patient when you're washing them, you know, [SP] helping them to the toilet [SP] giving them a bath [SP] you learn so much. I think, again, I don't think that a lot of nurses in hospitals [SP] maybe, um, something like intensive care they get the physical [SP] not so much the communication, perhaps but they get to do everything, don't they?"

As far as Grace was concerned, the fact that she was a staff nurse presented no barriers - in a hospice situation - to her provision of basic nursing care:

"... I've never gone around with the attitude 'Well, I'm a staff nurse, and I'm in charge.' We're all one... we're all here for the same reason. Obviously, there are limitations. [SP] Health care assistants can't do drugs and things, but other than that, you know [SP] and I'm [SP] just cos I'm a staff nurse doesn't mean I can't put somebody on the toilet [shared laughter] whereas some staff nurses I've worked with in the past, you know, 'That's for the health care assistants to do.'"

Carol held a senior nursing post but continued to do hands-on care:

"... you need to like doing very sort of basic things [SP]. You need to like caring for people in a sort of physical way."

AS "Do you do actually hands-on nursing?"

CE "Oh, yes. Not as much as I'd like to do, because I have other work to do, but I try to do as much as I can, yes."

Graham, on the other hand, was a manager who did "very little hands-on" care, believing that he could exert more influence on the care patients received by standing back from hands-on care and maintaining a clear management role:

"... there's obviously not much benefit in having me as [SP] as I am this morning, as just a pair of hands... for a long time I've sort of realised that actually you can't [SP] you know, you can't change practice that much just by your own [SP] standards. [SP] Some of that may rub off onto other people, but I think, you know, I always really saw... that there was, you know, there were other ways of actually influencing the care patients received, and actually that, you know, by making changes at that level... I suppose for me, it has to be based on the kind of benefit to patient care, but I don't feel the need for that to be me directly doing that."

'Hands-on' nursing lets you really get to know your patients

It was clear from the nurses' reflections on their provision of 'hands-on' patient care that it was not the tasks *per se* which were attractive but the opportunity that performing such tasks offered for the formation of close nurse-patient relationships. Undertaking some of these tasks might be unpleasant and even repulsive, but the fact that a nurse was undertaking them for a patient with whom they had developed - or wished to develop - a close caring relationship, and that her actions might encourage the development or deepening of the nurse-patient relationship endowed these very mundane, basic nursing tasks with special meaning.

Diane eloquently expressed her awareness of the significance of the performance of 'hands-on' nursing tasks for hospice patients:

"... some of the relationships you have are so close and intimate. They're still very professional, but there's something really, really special about it... I mean, I hate clearing-up shit and and I hate washing and blanket bathing people - the job itself, it makes me feel sick and I'm very squeamish... but the fact that the people who I'm doing it for is why I do it. I can't imagine anyone would want to be a nurse because of the physical things you do... but because you're doing it to the [SP] for the people, then you do it if that makes any sense at all... And that's what I mean by [SP] that, to me, is the essence of nursing."

Kerry recalled that, when she had worked as a district nurse, she had particularly enjoyed providing intimate care for people because of the opportunity it had offered her to become sensitive to patient need:

"... when you used to wash a patient, that's when you got to really know them, and know if people were in pain, and I loved that part."

Being a hospice nurse means that you enjoy hands-on care

Some of the nurses said explicitly that they enjoyed giving hands-on nursing care. Diane and Alison both felt that the opportunity to provide basic nursing care was one of the things that attracted some nurses to hospice work:

"... they tend to want to be at the bedside - they do tend to want to do the basic care."

(Diane)

One of the main reasons why Mary moved into hospice care, she reflected, was that this was one setting in which she could still provide basic nursing care:

"... one of the [SP] the main reasons why I wanted to come into this field of nursing [was that] we could still do real, proper, basic nursing care."

Kerry was enjoying her current role as a 'bedside' nurse:

"[I] might just go that little bit higher, but [I'm] quite happy doing the bedside nursing."

It was while she was caring for a terminally ill friend that Diane had realised how much she had been missing 'hands-on' patient care, so she had applied for a staff nurse post at a local hospice:

"... and I said 'I only want to be a D grade staff nurse. I don't want to do anything else... I just want to be a nurse.' And I absolutely loved it."

AS "When you said you just wanted to be a nurse, what was it you were trying to be?"

DL "Hands-on, direct contact, loads of contact with the family, because I found that the skills I'd picked up over the years came into their own in this setting more than anywhere else..."

Being a hands-on hospice nurse is being a real nurse

For these nurses, being a hospice nurse was being a 'real' nurse. 'Hands-on' nursing care was defined by them as being 'what nursing is all about' - the true nature of nursing. When Diane returned to nursing after a break, she told her prospective employers that she "just want[ed] to be a nurse" (see above) and for Marina, hospice nursing was "what nursing is all about".

Barbara felt that hospice nursing was "real nursing":

"... I would certainly agree that hospice nursing is what I call real nursing."

For Felicity, hospice nursing:

"... gets down to the very basic nursing of actually caring for somebody, which is what I wanted to do, rather than do ITU, where you wouldn't get to know the patients and things like that..."

Mark felt that, in striving to become more academic and professional, nursing had lost touch with its fundamental principles:

"... when I was a nursing officer in the eighties, we had this thing come in called the Nursing Process and suddenly we became professionally quite sort of academically orientated, and it was back to looking at how we would go about those things and looking behind the whole process of nursing. And we took our [SP] fatally, took our eye off the ball. We suddenly stopped the simple

'Sitting with Nellie' type nursing. We suddenly decided we could dispense with clinical nurse teachers, who I had been privileged to work with, who were extremely experienced nurses who would work with students and say, you know, 'This is how you do it' and 'Watch me'... And it all went - it just dissipated, really. And the traditional schools of nursing went; they became linked with universities as opposed to hospitals, and the whole scheme just drifted into the sand. [SP] I think the expression is 'Went into the sand'."

Diane also felt that changes in nurse training meant that nurses were not trained in as practical a way as they had been in the past:

"... here [basic nursing care] continues to be done by nurses [SP] and here it's probably not [SP] not representative of what happens in the health service. In the health service, the... trained nurses do very, very little hands-on care, and I don't think they really know how to..."

Hospice nurses do hands-on care... but sometimes they don't

Over the course of the interviews, it became clear to me that, while one of the attractions of hospice nursing was that it allowed nurses to undertake 'hands-on' nursing tasks (which enabled them to make close relationships with patients) there was some lack of clarity or ambiguity over who actually did hands-on care within the hospice environment.

Jonathan said that while he enjoyed hands-on care, it was the health care assistants who had the ultimate responsibility for this level of care and that, even in a hospice setting, he was not able to do as much hands-on care as he would like:

"... if you're coordinating, you have to take a step back because you [SP] you have to be able to see a big overview, which [SP] I could always do with seeing more of it. But, um, yes with your hands-on [SP] um, more so tend to be the health care assistants - and they are the [SP] the buck stops with them, and then the rest of us just get on and give them a hand where we can. The whole thing where drugs is a potential problem. Obviously symptom control takes a huge, um, bit of the nursing time [SP]. You're involved more with drugs than with washes and personal care."

Catrina observed that the amount of hands-on nursing she was able to do varied from one shift to another:

"... it varies from shift to shift. Sometimes I will do lots of hands-on nursing, then other times [SP] there just [SP] because of [SP] I don't know - how can I explain it? You do have to prioritise what you're doing, and like there's other priorities which aren't as much hands-on nursing which have to go before all of the other hands-on nursing things, so I think it varies from shift to shift."

The lack of clarity over who actually did the hands-on nursing care within hospices prompted me to seek clarification on this issue:

AS "... some... staff nurses have told me that they see themselves as hands-on nurses, but it sounds to me as though the health care assistants do most of that - the washing and the bed baths and the bedpans and so on. Is that generally true, or [SP]?

PR "It is generally [SP] it's generally true, because, you know, if you've got a drug round to do, and if you've got to prepare documents for somebody that's going home or [SP] you know, you have to [SP] somebody's been admitted... there are so many more new roles that, again, I'm still not [SP] er [SP] comfortable with doing [SP] not [SP] not confident, I'd say..."

(Patricia)

Perhaps my own lack of clarity here reflected an actual lack of clarity within hospices. On the one hand it was clear that all the nurses I spoke to enjoyed and valued 'hands-on' care and that this was one factor which had attracted a lot of them to hospice nursing, but on the other hand it seemed that doing hands-on care was not always possible for qualified nurses working within hospices. An examination of the changes the nurses perceived as affecting hospice care, discussed at the end of this chapter, may help to throw some light on this issue.

Hospice nurses nurse in a holistic way

A third theme which emerged strongly from the interviews in terms of what was involved in being a hospice nurse was that of holistic nursing care. Generally, this was defined as care which adopted a wide, rather than a narrow focus, taking into account not merely physical symptoms but also the psychosocial, emotional and spiritual factors in patients' lives, the needs and anxieties of patients' families and the use of complementary' therapies alongside conventional medical care.

Hospital nurses focus on physical problems

Felicity contrasted the holistic care which was provided in her hospice with the focus on physical symptoms which she saw as characteristic of other specialties:

"... I think we're treating the patient as a whole. Whereas other specialties are looking at the symptoms - mainly physical symptoms - palliative care treats the patient holistically, so they look at every [SP] psychosocial, spiritual [SP] every aspect of them. Also, it is not only them, but their carers as well, so it's drawing on everything, whereas I think in sort of surgical nursing or whatever, it's just the patient - their symptoms, get it cured, get them out. This is very different."

Catrina characterised care provided in other nursing environments as conforming to the "medical model" of illness:

"On wards and in other environments it's purely the medical model that you follow, whereas here you actually assess the psychological, you assess the social, you look at the whole person..."

Hospices make the most realistic claim to the provision of holistic nursing

Matthew had been attracted to working in a hospice by the fact that:

"They do make [SP] they make a much more realistic claim to be holistic which includes both the physiological and the psychological and the spiritual and all that than any other form of nursing that I've come across."

Steffie had worked in a number of specialties, but had found it easiest to provide 'holistic' care in a hospice setting:

"... if you're able to communicate, I think is very important for this job, and [SP] - you know, not just treating the problem, you know, treating the whole patient. It's totally [SP] I think out of all the areas that I've worked in, it's the most holistic care that I've had to give."

Holistic care: the 'theory-practice' gap

The provision of holistic care may be an ideal underpinning much of the teaching on nursing courses, but there would appear to be potential for a significant 'theory-practice' gap here.

Carol drew attention to the fact that:

"... there's a huge difference between sort of saying you're doing holistic care and actually doing it"

For her, hospice nursing involved:

"... thinking holistically, um, not just thinking holistically or saying you're thinking holistically and ticking it off but actually doing it."

Barbara was aware that lack of time could prevent the giving of holistic care in hospitals:

"... in your nurse training you're taught about holistic care of the patient, and that doesn't happen all the time on an acute ward [SP]. They don't have the time."

Holistic care depends on adequate resources

The provision of holistic nursing care was an ideal held by the nurses I spoke to and moving away from an environment in which it was not possible to achieve this ideal into one which facilitated it offered them an opportunity to provide what they defined as 'good nursing care'. But holistic nursing care was recognised as being dependent on having adequate staffing levels, which in turn depended upon adequate resourcing. This was made clear by Matthew:

"The resources to do the thing is essential. So that even within a hospice, if you stress a hospice and overload - they'll revert to a hospital model - it's the only way you can cope...So provided they have sufficient resources - because what it means is time, the ability to sit down with people and interact with them. And it's that simple thing that prevents half our hospital nurses actually doing anything about this, and people forget that. It's as simple as that - that if you're going to deal with [SP] if you're going to properly deal with psychosocial dimensions, it means time in human interaction; there's no other way to do it."

'Being there' for patients

Reflecting Heidegger's concerns (Heidegger 1973), a fourth dimension of the nurses' articulation of what it meant to be a hospice nurse centred upon a concern with 'being there' for patients. In nursing dying patients, the 'doing' aspects of nursing care become, at least to some extent, less important than 'being with' the patient - being quietly present to accompany patients on their journeys towards the end of their lives.

Standing alongside/accompanying

In talking about the needs of dying patients, nurses frequently used journeying discourse, portraying patients as being 'on a journey' towards the end of their earthly lives. The notion of 'accompanying' or 'standing alongside' patients represented part of this discourse, with nurses identifying for themselves a role in their patients' journeys.

Angela compared the situation of a woman in labour with that of a dying patient: two situations in which having someone to "accompany" the individual could be important.

Gordon saw part of his role as "getting alongside" dying patients and their families:

"... once you've sort of faced your own mortality, um, and come to grips with that, um, then you're able to, I think, help others, not by forcing your beliefs on them - I think it's, you know, getting alongside people and seeing people for who they are and helping them at whatever stage they are at and [SP] and showing a genuine love and concern for them..."

Mark reflected on the symbolism behind the name of the hospice which became the example that others in Britain would follow:

"... St Christopher's is called that because St Christopher was supposed to have taken Christ across the river on his shoulder - that's what the little logo of St Christopher's is [inaudible]. It's St Christopher holding Christ, and it's about taking people from this world into the next."

Being not doing

Some of the nurses contrasted the 'doingness' of hospital nursing with the 'beingness' of hospice work.

For Jonathan, one of the attractions of hospice nursing was that it allowed him more time to 'be' with patients:

"It seems to be just that idea of being with somebody, instead of doing [SP] having to do [SP] having to be active..."

Hazel had found that sitting quietly with patients often met their needs better than actively 'doing':

"... I've found over the years that perhaps to be too outgoing is not always the best - that if you can just quietly listen and be there for people, that's often all that they really need."

Being not talking

Some nurses reflected on the fact that it was sometimes more appropriate and helpful to remain silent when 'being with' patients, rather than looking for the 'right' thing to say:

"... you don't have to actually say anything [SP]. You can just be there."

(Barbara)

"I like to think that I deal with [relatives who are upset] quite well and I [SP] you know, I can say the right things [SP] or not say anything. You don't [SP] sometimes it's best just to be quiet and let them talk."

(Grace)

The importance of 'being there'

Felicity counted it an "honour" to be with patients at such an important time in their lives:

"It's a real honour to be able to be there, to make sure that the death is as comfortable and is what the patient wants it to be really [SP] that just to be allowed to be there when this is going on is just an amazing thing, and to be able to influence it as well - to make sure that it is comfortable or, you know [SP] however they want to die."

Time: a multi-dimensional concept in hospice care

The concept of 'time' emerged from the interviews as a central, powerful and multi-dimensional theme. Its availability was one of the major distinguishing and valued characteristics of hospice nursing and it was linked 'backwards' with adequacy of funding (adequacy of funding → higher

staff-patient ratios → more time to spend with patients) and 'forwards' with the quality of relationships it was possible to develop with patients. Time was recognised as a commodity which was not available in NHS acute care, as symbolic and characteristic of hospice care, as key to the practice of 'ideal' nursing care, as a highly valuable resource for dying patients, as a catalyst (in view of the short prognosis of some patients) for the provision of premium care, as a focus for 'getting it right' and as something which was uniquely valued in the hospice setting.

Hospital nurses do not have adequate time for patients

The nurses I interviewed contrasted the availability of time to care for patients in hospital settings with the time that was made available to them in hospices.

For Barbara, the time available to care for patients represented one of the main differences between hospitals and hospices:

"... I don't think the nurses [on acute wards] have the time [SP]. I think that's the biggest thing... and I don't think the nurses have the time to listen to what patients are saying, and to be there for the relatives..."

Sandra was aware of the extent to which lack of time contributed to nurses' inability to provide holistic care within the NHS:

"... I think perhaps that sometimes, there is [SP] there is quite a lot of time constraints in maybe a general hospital and... you concentrate on the present problem, whereas here we do look at underlying issues and [SP] and this is going to be a life-changing event for those around the patient as well, so you have to be aware of [SP] of that. Um, I think [SP] I think we have more time to spend with patients..."

Being a hospice nurse means having time for patients

Angela had chosen hospice nursing:

"[b]ecause I knew I would have more time at the bedside... I knew that there would be a better nurse-patient ratio, so you could give that time."

For Felicity, having time meant that it was possible for nurses to get to know their patients:

"You can nurse. You can get to know your patient... You get to know your relatives [SP] you know, it's just [SP] and you can spend time with people, which is really, really important."

Stella was attracted to working in a hospice partly because she liked the idea of:

"... just having more time to be with people, rather than rushing to do stuff and get on to the next patient - just having time to be with people..."

Spending time with patients is valued in hospices

In NHS hospitals, time is at such a premium that nurses have to focus on tasks to be performed. In these circumstances, spending time talking to patients may be regarded as unacceptable. In hospices, on the other hand, staff at all levels recognise the importance of 'being with' patients and place a positive value on this aspect of nursing care.

As a manager, Alison had observed how difficult it was for some nurses who came to hospice work from an acute setting not to feel guilty when they sat with patients; because in a hospital setting they had never been "allowed" to do this, but:

"... if a nurse needs to be beside somebody's bedside, that to me is more important than rushing and doing somebody's bath or whatever..."

The significance of time at the end of life

For the nurses I spoke to, time represented, on the one hand, a precious resource. A second dimension of time which emerged from the nurses' narratives was the importance and significance

of the period leading up to patients' deaths. Here, the focus was less on time as quantity and more on time as quality.

Marion recalled a comment made by Cicely Saunders (the founder of St Christopher's Hospice who is seen by many as the founder of the modern hospice movement):

"... I can't remember exactly what Cicely Saunders said but it was along the lines of the small length of time at the end of someone's life is probably more important than the part that's gone before [SP] to some people."

Mark also regarded the end of life period as having special importance:

"... what is for me fundamentally one of the most important times of anyone's life is when they leave it... "

Some of the nurses spoke of the criticality of the end-of-life period and the responsibility and opportunity this signified for nurses:

"... you only have one chance to get it right..."...

"... I've got this strong sense of doing it right and doing it first time and only having that chance to..."

(Patricia)

"I think it's ingrained in all the staff here how important it is to grab the moment. I know that's a bit of a cliché but it is. If your patient has started to open up about a worry that you know that you can grab that moment..."

(Marion)

These nurses who cared for people approaching the ends of their lives felt that they had important contributions to make in ensuring that this time was as good as it could possibly be for their patients, and for the patients' families:

"... I think we're good at looking at reversible causes, reversible symptoms and getting on top of those, and we can then provide an important [SP] it might be a small window of time, but you know, nevertheless, a good-quality time for that patient and family."

(Marion)

"... sometimes... you're not seeing the best of [patients] [SP] you're not seeing what they've been in life. You're not seeing what they were capable of - you're only seeing the residue really, and, er, it's sort of understanding that and still being able to make a connection and being able to be respectful and kind with them, and making those last days [SP] weeks, months, whatever they are [SP] really count. I think that's the important thing."

(Jenny)

A paradox of time

Two of the nurses expressed their awareness of a paradox involving time within the hospice setting. While it was true that nurses had more time to spend with patients, there was a sense of urgency in the nurses' awareness of what they hoped to achieve for those patients in the time that was left to them:

"I think it's probably [SP] although it's not always [SP] a slower, quieter pace of working, but everything needs to have happened yesterday - there's a certain sense of urgency [inaudible] because time is always on your heels, sort of thing."

(Emily)

"... in many ways, we're more active because there is this realisation that someone's life is now getting shorter - the span of their life is getting shorter, so we do have a real focus on achieving as much as we can for that person. I think we're quite fired and focused."

(Marion)

Time is money

The luxury of time does not come cheap. Gordon drew attention to the fact that, in order for hospice nurses to have adequate time for their patients, higher staff:patient ratios were essential:

"... I think it's, you know, understood in palliative care especially that time is important - to give time to people, time to care, time to listen or whatever, um, and there are certainly efforts to try to make that come about... providing a fairly good staff ratio and [SP] staff: patient ratio and things..."

Matthew recognised that the care that was possible within hospices depended upon resources, without which they would "revert to a hospital model":

"... they have provided sufficient resources - because what it means is time, the ability to sit down with people and interact with them."

Perceived threats to hospice nursing care

Some of the nurses whose words I have used as a way in to an understanding of what it means to become and to be a hospice nurse conveyed their concerns about the future of hospice care. These concerns focused particularly on changes which were affecting hospices in general, including financial restraints, higher levels of patient demand and turnover, the number and quality of nurses, availability of time and increasing 'medicalisation'.

Financial restrictions

Jonathan was aware that financial restrictions on health services were not confined to the NHS:

"It's gone from being very laid-back and having lots of nurses to somewhere that's had to be more financially accountable... we have to be more efficient and accountable, because obviously people are donating money to be spent appropriately."

Marina was also aware of financial restrictions affecting her hospice:

"... there's a lot of money constraint here as well [as in the NHS] because it's voluntary - there is a very small percentage of NHS funding - about 10% or something so... they have a lot of fundraising and stuff going on here..."

Greater demand and higher patient turnover

With increasing public awareness of the levels and types of patient care available in hospices, patient demand has increased and there is a greater turnover of patients, with hospices attempting to return patients to their own homes when possible and acceptable.

Alice said that patients tended to stay in her hospice for shorter periods of time than had been the case in the past:

"Well, it's much less than it used to be. Because as soon as they come in, you're planning to get them out, unless they come in to die."

Stella observed that improvements in diagnosis had changed the patterns of patient care:

"... people are being looked after in their own homes and... because people are diagnosed as having a palliative [SP] not curable [SP] condition earlier, which means that they are in and out of hospices - so they're spending a lot of time in their own home as well as being in their own home [sic] for end of life issues..."

Increased pace of working

Several nurses felt that the general pace at which hospice nurses had to work had increased. Stella described this in terms of "pressure" exerted on nurses:

"... pressures are being put on all of the nurses to actually do more [SP]. Patient turnover is more rapid, definitely. I mean we [SP] we would [SP] if somebody had died or had gone home, the bed would have been empty for days. That doesn't happen any more. Much more often, we're being telephoned 'Have you got a bed? Can we bring a patient in this afternoon?' When perhaps the patient has only vacated the bed, in whichever way they're vacating it, that morning. But I mean that's [SP] that's partly due to the pressures on the hospitals and the fact that patient expectations are different..."

Mark, while aware that some hospice nurses felt that they were being expected to do more and more, was not convinced that this was the case:

"... hospice nurses have always said Oh, they haven't got as much time as they used to [SP]. You'll hear them saying that because [inaudible] busier [SP] busier and busier, which I'm not sure that's true, because I think they've always been quite busy..."

Number and quality of nurses

As a nurse manager, Alison was aware that more young people were now coming into hospice work, and suggested that this might be related either to the lack of hospital jobs or to lack of job satisfaction in the NHS. Janet had observed that staffing levels and quality had fallen in the hospice where she worked:

"The doctors seem to leave sort of snotty notes and [SP] things, um, and I don't know if that's because some of the nurses are maybe not as good as [SP] the turnover is higher than it used to be, and there were more staff and who were, you know, really good nurses. Maybe some of the staff now are a little bit sort of slacker and not so knowledgeable. I don't know if they've received the training that they need, and I think there were more people before who were really [SP] often

quite religious people, very caring people, and I think the staff [SP] some of the staff are sort of maybe younger, and have come [SP] maybe from abroad, um, and it's just a job."

Time: a diminishing resource

Some of the nurses felt that there were now restrictions on the time available to care for patients:

"... I feel we should have more time with the people, but that's changed a little bit cos we are a bit more stretched - we definitely are more stretched..."

(Angela)

"I'm aware there's a time limit, you see, that even when somebody's died there's still [SP] you know, you can't spend all afternoon talking to relatives, much as you'd like to, and that's something I still struggle with a little bit."

(Patricia)

Joining the mainstream: Are hospices becoming more like the NHS?

Some nurses suggested specific ways in which increased demand and greater financial stringency manifested within hospices (see above). Others suggested that hospices were moving away from a model of care which was clearly distinguishable from the medical-model basis of NHS hospital care and towards a situation in which they became more like the NHS.

In the time she had worked in hospices, Carol had seen them move closer towards the "mainstream":

"... over the 25 years or whatever since I first worked in a hospice, of course, things have moved on hugely and palliative care is much more part of the mainstream - you know, there's palliative care

wards at the Marsden and there's palliative care going on to some degree or other in elderly care wards and so on..."

Mark, whose first encounter with hospices had left him with a view of a system of care which was "slightly off-beam" also felt that they had "become so much more mainstream."

Jonathan also expressed awareness of change:

"Hospice care has changed, I think. It's become much more [SP] um [SP] a lot more like the NHS, to be honest, than I would like."

Diane, whose images of a patient requesting to have a horse brought to the hospice and of another patient sharing her room with her pet rabbit so vividly conveyed the way in which hospices attempted to provide individualised patient care (see Chapter 9), was aware that such care was perhaps becoming less easy to provide:

"I don't know how good we are at that now. I think they might be a bit more tight on it. It's become a bit more clinical... "

AS "Have hospices changed a lot in the time that you've been working?"

DL "Well, this one has. It's become [SP] I think it's become more, um, more a clinical environment."

Felicity was aware of a general tendency within hospices for the balance of control to shift away from nursing and towards medicine:

"Well, I think [it would be helpful] to try to make the nurses [SP] take more control. I think, you know, at the moment I feel it's very much sort of medically led. It used to be very, you know, nursing, and then because we had such sort of [SP] nurses with varying degrees of experience, it went [SP] became quite medicalised, and I think [SP] it's not only here - speaking to other nurses, it

seems to be hospice wide, and so it's just for the nurses to take back some of that control and responsibility..."

Matthew called attention to the fact that traditionally, hospices had represented a model of care which was easily distinguishable from NHS care, but that this model was under threat:

"... there's been claims that it's been medicalised from a previously less medical model, and there could well be some truth in that, and that would be a natural process in a sense, but perhaps one has to guard against it. Um, yes, so there's the medicalisation and there is a tendency to turn it into... a more hospital environment, as you just see sometimes by the physical dimensions. And one has to remind oneself in the end that this is a totally different approach."

Chapter summary

In this chapter I have drawn out five inter-related aspects of hospice nursing which seemed to be particularly meaningful to the nurses in terms of what it meant to be a hospice nurse: the opportunity to provide 'good' nursing care, the fact that hospice nurses could provide 'hands-on' (or 'basic' or 'bedside') nursing, the holistic nature of hospice care, 'being there' for patients and the availability of time. These characteristics of hospice care appeared central to their identities as hospice nurses and made sense of their continuing to work in the hospice environment.

These five aspects of hospice care helped to define for the nurses what it was that hospices were able to offer but that NHS acute care could not, and also made clear the ways in which they, as nurses, were different from nurses working in NHS hospital settings. Being a hospice nurse *was* being able to provide good 'hands-on' holistic nursing care, 'being there' for patients and having time, and these aspects of hospice nursing allowed the nurses to put into practice the ideals they had formed before and during their nurse training.

Through a process of identity-formation involving the development of ideals, the testing out of their identities until they managed to achieve congruence between these ideals and their working environments, the nurses had arrived at a point of balance. In Maben et al's terms (2006/2007),

they were 'sustained idealists'. They had been uncompromising in their search for an environment in which they could practise their ideal nursing and for them, being a hospice nurse was being the nurse to which they had aspired.

The nurses' current state of balance, however, was perceived by some to be under threat and the distinction on which the nurses had been able to call to mark out their current 'hospice nurse' identity was perceived as being challenged. Financial restrictions, increasing patient demand and turnover, lower staffing levels and decreased availability of time to be with patients had led to a situation in which it seemed to some of the nurses that hospices were 'becoming more like the NHS'.

PART 3

REFLECTIONS ON A JOURNEY

Chapter 11: Discussion and conclusions

"Who are these nurses that willingly seek out the presence of death every working day? What is the life journey that has led them to this work?" (Gaydos 2004:18)

"Who but a fool or a saint would deliberately expose themselves, day after day, to intolerable pain and sadness?" (Cassidy 1988:5)

Meaning in context

It was my curiosity about the life journeys that led nurses to work in English hospices that started me off on my own journey of exploration. Like Gaydos and Cassidy, I wanted to find out what these nurses brought to, and took from, their work with terminally ill patients - what were the attractions of nursing in an environment where death was an everyday event?

My initial conceptions were (as I noted in my Research Journal early in the research process) "very naive". I felt, in a rather intuitive and non-academic way, that somehow these nurses must be 'special'. Perhaps they were selfless, devoted individuals who accepted the pain of loss as part of having a job with meaning, or perhaps they were not 'special' at all and operated on as superficial a level as they could, avoiding getting involved with their patients to such an extent that they would suffer from the constant losses. These nurses, I wrote in my Research Journal on 21 June 2005, "must be either women who couldn't hack it in A & E or acute wards or the operating theatre or whatever and preferred to work in a low-tech (less demanding in some ways?) environment *or* angels/special/unusual people." My main interest, in the early days of the research, was in the possible link between religious/spiritual beliefs and the choice of hospice work. Could it be, I wondered, that many of these nurses would turn out to have a belief in an afterlife which endowed with special significance the time leading up to an individual's death? This idea was neatly countered in early discussions at Hospice One with a nurse who suggested that it might make more sense to entertain the idea that hospice nurses tended *not* to believe in an afterlife. If we only live once, she suggested, then surely the end-of-life period would be viewed as an extremely important time for a patient.

My initial ideas were only partly supported by the results of my study. It *was*, I discovered, arguable that hospice nurses were 'special' in some ways, but the religious/spiritual thread I thought I might find weaving strongly through the stories the nurses told me of their life journeys was not clearly visible. What *was* visible was something which had not been in my consciousness at all when I commenced my study, but which made a great deal of sense in the light of recent developments within health services in the UK. As I wrote up my study, I was encouraged by the fact that I could not easily be accused of producing with my respondents the data I had hoped and expected to produce. The journey we took together took me to a very different place from that to which I had expected to travel.

Following Heidegger (1973) and Gadamer (1988), I envisaged my research as being focused on *meaning* - I wanted to reach an understanding of the meanings that nurses attach to the experiences they identify as having brought them to work in English hospices. In a report on their study of nurses' accounts of their choice of psychiatric nursing, Moir and Abraham (1996:296) state explicitly "This paper is not concerned with students' 'real' motives for choosing psychiatric nursing, but rather how they managed to construct justificatory accounts for pursuing a career in this field." In my study, similarly, it was nurses' discursive *accounts* of their experiences, rather than the experiences themselves, which were the primary focus. By entering into dialogue with a group of hospice nurses, I hoped that it would be possible to invoke the hermeneutic circle and develop my understanding of their interpretations of their life journeys through a 'fusion of horizons' (Gadamer 1988:350).

Telling my own story to the nurses I interviewed helped to establish some common ground between us. It also helped the nurses to 'make sense of' my interest in my research topic and, in talking about my past, *I* was 'making sense' of my own history by relating past experiences to present concerns. Thus, in inviting the nurses to talk about their own journeys, I had an opportunity to make sense of my own life journey. As researcher, I played an active part in the creation of the data. In responding to my questions, the nurses were "reflecting, reinterpreting, and making sense of their experience" of 'becoming' and 'being' a hospice nurse, narrating their experiences "in a way which was coherent with their own self-interpretations, meanings, and intentions" and with what they perceived as my own intentions and meanings (Rasmussen et al 1995:351). In entering into

dialogue with the nurses, I was able to observe the vital role that narrative plays in the formation of identity and how, as active, interpreting beings, we move back and forth between past and present in such a way that 'being' informs 'becoming' while 'becoming' is interpreted in the light of current experience. The 'stories' the nurses told me are similar to the 'stories' we all tell ourselves and other people in order to make sense of who we 'are'.

In line with the phenomenological perspective, we find here evidence of an active process of occupational identification which may represent part of an ongoing process throughout life, in which the 'stories' we tell change to accommodate new perspectives and understandings. Also in line with a phenomenological perspective, my analysis of my data required me to bring my own interpretive and intuitive faculties into dialogue with the interview texts, and my findings do not constitute a once and for all representation of reality. As researcher, I was an active presence in my own research and constructed a point of view that is "both a construction or version" and is consequently and necessarily *partial* in its understandings (Stanley and Wise 1993:6-7).

An active process of 'becoming' and 'being'

In Chapters 6 through 10, we observed the way in which the nurses gave accounts of their experiences in an attempt to make sense of their life journeys. We observed an active process of 'progressive becoming' involving the development of occupational values and ideals (which I term the nurses' 'being-towards-care') and the attempt to achieve congruence between these ideals and values and the work the nurses do. The search for occupational congruence, I suggest, involves various processes to which we might refer as the 'work of the self' - the refinement and negotiation of occupational identity by 'testing out' jobs (and later, nursing specialties) and refining one's occupational identity first to see oneself as a 'nurse' and, through time and experience, as a 'hospice nurse'. In talking about the jobs and specialties they 'could not' have done, the nurses drew attention to a process of 'identification' as a specific aspect of occupational identity formation. Here, they were able to identify what they 'were' by stating what they 'could not' be.

In articulating their dichotomous perceptions, the nurses in my study were refining and affirming their own identities as hospice nurses. Identifying in NHS care aspects which failed to satisfy their

own being-towards-care enabled them to clarify their own 'hospice nurse' identities, in the same way that some of them had previously tried out different occupational identities and later tested out different nursing specialties. This drawing of contrasts between general nursing (or acute medical/surgical nursing) on the one hand and chosen specialties on the other is a feature of several other studies (De Vries 2000; Hopkinson et al 2003; Moir and Abraham 1996; Rasmussen et al 1995; Heskins 1997; Fisher 1996).

In a report on her study of the effects of role models on choice of hospice nursing, De Vries (2000:85) suggests that, for some of the nurses, the decision to work in a hospice was "related to a rejection of the hospital model of care and practises [sic] that nurses were experiencing while working in the hospital environment and the difficulty in providing care of the standard they wished to." The desire to make such a move, however, "developed slowly and for a variety and combinations of other reasons" (ibid). My own data suggest that the nurses to whom I talked make sense of their own moves into hospice care by identifying in hospice an environment in which their ideals and values could best be put into practice. Few recalled having developed a 'nurse identity' at the point of leaving school, and none recalled having had an inclination at this stage to go into hospice work. At this point, it seems, their occupational identity had been in a state of potential or becoming, and it was only through 'testing out' other jobs and later, other nursing specialties, that they were able to arrive at a point of balance between their being-towards-care and their work. The dimensions of the contrasts the nurses drew between acute hospital care and hospice care represented the ideals embodied in nurse education, including holistic care and close nurse-patient relationships, but these were ideals which the nurses had found themselves unable to put into practice within NHS settings.

In their discussion of compassion in nursing, Firth-Cozens and Cornwell (2009:5) observe that "Although compassion is regarded as important to the ethos of most health care professions, and features to some extent on most curricula, the core of teaching, training and practice, certainly within clinical medicine and increasingly in nursing, adheres to the biomedical model." There is, it appears, a potential disjunction here between nursing as it is taught, with a focus on 'professionalism' and critical thinking (Roberts and Barriball 1999) and the traditional ideals

(including patient-focused holistic care and close nurse-patient relationships) to which it continues to adhere (Allen 2004).

There is evidence to suggest that nurses in the UK and elsewhere emerge from their nurse training with a strong set of ideals in terms of how they wish to work as nurses (Day et al 1995; Maben et al 2007; Maben and Griffiths 2008) and studies of nurses caring for dying patients have found them to have clear ideals of care. Thus, Rasmussen et al (1995) in their study of Swedish hospice nurses, found that they were "idealistic" in terms of the care they hoped to provide to patients and Hopkinson et al (2003:528) in a study of UK nurses caring for dying patients in hospital, identified strong personal ideals which represented "a personal view of how dying people ought to be cared for".

Ideals of nursing

In my study of hospice nurses, several dimensions of 'ideal' nursing emerged clearly as having importance and meaning.

'Hands-on' patient care

Other studies have found that nurses place a high value on 'hands-on' patient care - that is, on physical tending tasks such as washing, feeding, bathing and assisting patients to the toilet (Allen 2001; Heskins 1997; De Vries 2000). Studies have found that some nurses identify the provision of such nursing care as the "essence" or "cornerstone" of nursing (De Vries 2000; Melia 1987).

For the nurses I interviewed, the opportunity to give 'hands-on' nursing care was an important attraction of hospice work. As suggested by other writers, however, (see, for example, Bradshaw 1997; Chambers and Ryder 2009) it was not the nursing tasks themselves which were valued but the relationships such care facilitated. For these nurses, rather than being tied to any set of physical tasks performed, the concept of 'hands-on' care was symbolic of a close and meaningful relationship with patients, which to them was another important dimension of 'good' or 'ideal' care. I suggest that the popularity of midwifery and children's nursing among the nurses I interviewed may relate to the level and type of nursing these nurses sought to provide. Elaine compared the

vulnerability of those coming into the world with that of those in the process of leaving it - both groups require very high levels of physical tending. For these nurses, I suggest, making physical contact with patients was part of the process of making contact with them emotionally, and 'making contact' enabled them to 'make sense' of their nursing roles.

Holistic care

Allen (2004:274) observes that "A key plank of contemporary nursing ideology is the claim that nurses are the providers of individualised holistic patient care" and this feature of nursing has been drawn upon to support nursing's claims of "autonomous professional status" (Allen and Hughes 2002:105). The provision of care which takes into account patients' emotional, psychological and spiritual needs, as well as their physical needs, emerged clearly as an ideal in my discussions with hospice nurses, and other studies have pointed to the centrality of the concept of holistic care within current UK nursing ideology and education (Maben and Griffiths 2008; Maben et al 2007). Rasmussen et al (1995) in their study of hospice nurses, found that they expected and hoped to care for the "whole human being" (p348) and caring for the family as well as the patient represented part of this ideal. In identifying the family as a focus of nursing care, the nurses in my study, like those in Rasmussen et al's (1995/1997), were rejecting medical models of care and acknowledging that the patient was not only more than a body but also entwined in a network of social relationships.

Time

One theme that emerged strongly from my data was the value and importance of 'time' in hospice nursing. This emerged as a multi-dimensional concept. Having adequate time to care for patients was seen as essential to the type and level of care the nurses wished to provide for their patients, and while it was more readily available in the hospice than in the NHS, some of the nurses were also aware of a sense of urgency and a need to "get things right first time" for patients nearing the end of their lives. As observed by Harding (1999:17) the value of time, both to nurses in general and to those caring for dying patients has been acknowledged by several writers. In Rasmussen et al's work on hospice nurses in Sweden (1995: 1997) time was a strong theme in the nurses' narratives and Hopkinson et al (2003:528) also found that having adequate time to act on dying

people's wants and needs was "[o]ne thread of the personal ideal" for nurses caring for dying patients in hospital. In his study of nursing as a therapeutic activity, Ersser (1997:173) also identified "temporal or time qualities" as "[a] salient feature" of nurses' and patients' accounts of nurses' "presence".

Nurse-patient relationships

Allen (2004:271) notes that emotionally close nurse-patient relationships represent an important part of "contemporary nursing ideologies" and the claims made by nursing about its unique contribution to society. There is plenty of research to suggest that the formation of nurse-patient relationships is highly valued by nurses (Beck 2000; Benner 1984; Day et al 1995; Maben and Griffiths 2008) and it is, therefore, not surprising that for the nurses to whom I spoke, the formation of close relationships with patients represented one important dimension of 'good' nursing care. Nurse-patient relationships also emerged as a key theme in nurses' narratives in Rasmussen et al's (1995) study of Swedish hospice nurses and Savage (1995:124) points to the morale-boosting effect of "the reciprocal nature of [nurses'] relationships with patients" as one important outcome of the availability of the time which is necessary for nurses to become 'close' to patients. These relationships, I suggest, are essential if nurses are to be sufficiently in tune with their patients to be able to detect small changes in their condition and to respond swiftly to individual requirements.

'Being with': The nurse as companion to the dying

The opportunity to simply 'be with' dying patients - to attend in a way which conveyed a readiness to listen and be wholly present - represented an important requisite for 'good' nursing for the nurses I interviewed. "Being with" suggest Barnard et al (2006:6) "expresses recognition of the need to assimilate and grow in a nurse-patient relationship". Some of the nurses in Benner's (1984) study expressed awareness of the importance of "being there" to both nurse and patient (p322) while Ersser (1997:199) refers to the "protective value of presence ". The hospice nurses in Rasmussen et al's Swedish study expected and hoped "to be present both mentally and physically, just to be there, and to be there completely - mind and body" (1995:347).

The 'journeying' discourse used by some of my respondents is, I suggest, closely related to (indeed, integral to) the Heideggerian notion of 'being there', and the imagery of the journey and of the nurse as a companion to the dying is a theme which appears frequently in the nursing literature (Barnard et al 2006; Campbell 1984; Woodward 2007; Cassidy 1988). "He who would be a companion to the dying" writes Cassidy (1988:5) "must enter into their darkness, go with them at least part way along their lonely and frightening road." 'Being with' represented for the nurses I interviewed an important aspect of the nurse-patient relationships they valued so highly, and was clearly dependent on having adequate time, for which high nurse-patient ratios were essential.

Individualised patient care

The provision of care which is tailored to individual patient need represents a clear 'ideal' of nursing care as expressed in contemporary nursing theories and textbooks, and as taught in nurse education (Allen 2004; Maben et al 2007). Other studies have found that this ideal is espoused by nurses at all stages of their training and working experience (Day et al 1995; Maben and Griffiths 2008; Maben et al 2007). The ability to provide care to meet individual need was one of the attractions of hospice nursing discussed by my respondents. It enhanced and made possible the close relationships they sought with patients and was dependent upon the provision of high nurse: patient ratios.

Provision of high-quality nursing care

The nurses I talked to were passionate in their desire to provide high-quality nursing care which met their ideals of good care. In Heskins' (1997) study of ICU nurses, being able to work to "their own high standards" was one of the reasons nurses chose this area of work (p70) while Rosser and King (2003:209) found that hospice nurses "expected to provide a high standard of care for patients". Maben and Griffiths (2008) in a study of hospital nurses, found that their results highlighted "the passion that nurses felt for their work and for being able to deliver high-quality care". "This" they say "is what they came into nursing for - to *'make a difference*'" (2008:8) (authors' italics).

Realities of everyday nursing practice

My research suggests that the nurses to whom I spoke had experienced a conflict between discourses of 'ideal nursing care' on the one hand and management discourses focusing on effectiveness and efficiency on the other.

Maben et al (2006) observe that research in several countries provides evidence of the existence of a 'theory-practice' gap in nursing, which means that the ideals with which nurses emerge from their nurse education frequently cannot be put into practice. Maben et al's own research in the UK (Maben et al 2006; Maben et al 2007) confirms the disjunction between nursing theory and nursing practice and Melia (1987:54) suggests that this disjunction is widely recognised and "almost a part of the nursing folklore". Allen (2004:279) calls attention to the "mismatch between real-life nursing work and the profession's occupational mandate...with its emphasis on emotionally intimate therapeutic relationships with patients".

Cutbacks in NHS spending are responsible for many of the discrepancies between nursing ideals and the realities of everyday nursing (Allen 2004; Ball and Pike 2009; Beckford 2007; Chambers and Ryder 2009; Gardham 2006). "Resource constraints "observe Chambers and Ryder (2009:53) "can make compassionate care prohibitive".

One obvious effect of financial restrictions is a decrease in the number of nurses employed; there is much evidence that cuts in NHS spending have resulted in recruitment freezes which have meant not only that new nurses find it difficult to find jobs within the NHS but that patient care is compromised (Ball and Pike 2009; Chambers and Ryder 2009; Gardham 2006; Maben et al 2006/2007; McCartney 2008). Staffing cuts, in combination with increasing patient demand (Ball and Pike 2007; Firth-Cozens and Cornwell 2009), higher levels of patient turnover (Maben et al 2006; Chambers and Ryder 2009), greater patient acuity (Cohen et al 2004; Maben et al 2006; Mackintosh 2007; Chambers and Ryder 2009) and increased levels of administrative work (Allen 2001; Chambers and Ryder 2009; Maben et al 2006;2007) have combined to significantly increase the workload of NHS nurses.

The discourse of NHS managers, focused as it is upon efficiency, cost-effectiveness, targets and performance management (Allen 2004; Chambers and Ryder 2009; Maben et al 2007) is clearly at odds with nursing ideology, with its focus on holistic, individualised patient care and close nurse-patient relationships. The focus of managers on efficiency and cost-effectiveness, some writers have suggested, has meant that the "invisible" work of reassuring and listening to patients and simply 'being with' them is marginalised simply because it is not measurable (Chambers and Ryder 2009; Firth-Cozens and Cornwell 2009; Maben 2008).

Severe pressure on nursing staff leads to a situation in which it is very difficult for nurses to provide care which is holistic and individualised, and instead of qualified nurses providing direct patient care, in today's NHS they find themselves supervising other staff in the undertaking of 'hands-on' care (Allen 2001; Chambers and Ryder 2009; Maben et al 2007) With the physical care of patients increasingly delegated to less qualified staff, spending time with patients is devalued so that nurses "feel guilty" when they do so (Firth-Cozens and Cornwell 2009:8).

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Davies (1995) uses the concept of the "Polo mint problem" as a metaphor for the situation in which nurses spend most of their time working around - rather than with - patients and supervising the labour of other staff. Lack of time to spend with patients means that, as Benner (1984) observed in a report on an American study, nurses are not able to form close relationships with patients so that one important source of satisfaction - the 'human connection' - is not available to them (see also Ersser 1997; Chambers and Ryder 2009; Firth-Cozens and Cornwell 2009; Maben et al 2006; 2007). In their Swedish study, Rasmussen et al (1995:347) found that the hospice nurses they interviewed referred to the difficulty of establishing a close relationship with patients and their families in hospitals, in part because of time constraints. Maben et al (2006:471) found that recently qualified UK nurses were discouraged from becoming "involved" with patients, with established staff giving messages that it was undesirable and inadvisable for them to form relationships and that they should "harden up" and keep their distance.

Several studies have drawn attention to the lack of support nurses receive in the NHS to help them to deal with discrepancies between the care they would like to provide for patients and the realities of everyday practice (De Vries 2000; Davies1995; Maben et al 2006; 2007). Rasmussen et al

(1995:351) found that the "supportive working environment" was one of the key attractions of hospice work for the nurses they interviewed.

Ideals confront reality

There is much evidence that the disparity between nursing as it is taught and nursing as it is practised is a source of a great deal of frustration, dissatisfaction and disillusionment for nurses. Allen (2004:271) observes that the "mismatch between nursing's culture and ideals and the structure and constraints of the work setting" is "a chronic source of practitioner dissatisfaction". A "chronic tension" exists, notes Allen (2004:281) "between the job nurses are educated for and that which they actually do". Work by Maben et al (2006; 2007) supports Allen's view, and other work in the UK and elsewhere indicates that this is a widespread problem for the nursing profession (Chambers and Ryder 2009; Donnelly 2007; Davies 1995; Heskins 1997; Mackintosh 2007; Vanhanen and Janhonen 2000b). Nurses' frustration and their inability to put their ideals into practice may lead to stress, burnout, disillusionment and, in some cases, a decision to leave nursing (Maben 2008:337) and this, in turn, may lead to poorer quality of care for patients (Maben et al 2007:111).

The ways in which nurses respond to dilemmas of idealism (which, for my nurses, were embodied in their narratives of 'becoming' and 'being' hospice nurses) have been explored in a number of studies. Melia (1987) found that student nurses adapted quite readily to the realities of nursing once qualified, but other studies have not found this to be the case. Kiger (1993) found that some nurses did adapt by modifying their "images" of nursing, but that others found it difficult to adjust and, in extreme cases, rejected nursing altogether. Day et al (1995) found that, by the end of their fourth year, Canadian nursing students had clearly developed nursing ideals which they were determined not to compromise. Maben et al found that the only nurses who were able to put their ideals into practice were working in environments with good staffing levels and good staff support. In less supportive environments, nurses either had to abandon their ideals or attempt to maintain them in the hope of finding a nursing environment where they could put them into practice (Maben et al 2006/2007; Maben 2008).

The concept of 'cognitive dissonance' (Festinger 1957) or 'ideological dissonance' (Hunter 2005) has been little used in nursing studies (Mackintosh 2007) but could usefully be invoked in exploring why nurses shun some areas of work and embrace others. The nurses in my study frequently referred to aspects of their NHS work which had led them to move into hospice work. In the same way they recalled having identified occupations they 'could not' have done and nursing specialties they 'could not' work in, they were now making sense of their move away from the NHS and towards hospice work. Other studies in the UK and elsewhere also refer to nurses' accounts of 'rejecting' NHS nursing environments to work in hospices (De Vries 2000; Rasmussen et al 1995; Palmer 1991; Rosser and King 2003).

What 'is' nursing?

Kagan, in her foreword to Chambers and Ryder's recent book (2009) suggests that "where you nurse determines who is a nurse and what you perceive to be nursing" (pviii). I would argue that, while there is evidence to suggest that this is true for at least some nurses, it also makes sense to reverse the statement: who is a nurse and what you perceive to be nursing determines where you nurse. In support of Kagan's view, there is evidence that, for many nurses, 'real' nursing is the nursing that takes place on acute medical and surgical wards, which is to a large extent medically prescribed and of a technical nature, and where rewards attach to seeing patients restored to health (Happell 1999; Kiger 1993; Melia 1987). This is likely to be the type of nursing with which students become most familiar in their training and my evidence suggests that it is only relatively recently that nurses have been offered the opportunity to undertake training placements in hospices. While the nursing profession may retain its ideals of holistic, patient-focused nursing, many nurses work in environments focused on 'cure' rather than 'care', and it is in these environments that they are least likely to be able to put their ideals into practice.

For Heidegger, caring for and about other people is central to our being as individuals (Heidegger 1973). The nurses I interviewed, I suggest, had identified 'caring' (which for them involved hands-on patient care) as what nursing 'is' and had deliberately sought out an environment in which they could put their ideals into practice. A number of the nurses (including Matthew, for whom hospice nursing was "about caring more than it is about treatment" and Carol, for whom the

"communications side" was more interesting than being a "high-tech wizard") explicitly identified hospice nursing as involving 'care' rather than 'cure'.

Several writers have identified environments providing care to terminally ill patients as places where the commonly-espoused ideals of nursing can best be put into practice (Bradshaw 1996:410; Lush 1991:34; Field 1989:17; Tremayne 2003:17; De Vries 2000:85). The nurses in my study sought out hospice nursing because it was an environment which allowed them to practise nursing as they felt it should be practised. To them, hospice was "what nursing is all about" (Marina), "nursing in a purer form " (Matthew) or "proper nursing" (Catrina). The principles on which hospice care is based - holistic, patient-centred care which is made realisable by high nurse: patient ratios - echo the ideals embodied in nurse education and nursing's claim to professional status. In coming to work in a hospice, the nurses had (as Grace stated explicitly) "refound nursing".

Equilibrium under threat

Through the 'work of the self' and their search for occupational congruence, the nurses in my study had reached a point of equilibrium - in hospice they had found an environment in which their ideals of nursing could be put into practice. This state of balance, however, was perceived to be under threat, with concerns being raised about hospices' increasing need for accountability, higher patient demand and turnover, lower staffing levels, increasing workloads and a tendency for hospices to become more "medicalised " and more "like the NHS". These concerns are borne out by James and Field (1992) who express concern about the future of hospice care. They observe (1992:1363) that the number of hospices in Britain increased from under 15 in 1965 to over 430 in 1991 and argue that, with the dissemination of good practice in terminal care and increasing cooperation with mainstream health services, hospices have become "routinised" (op. cit.:1363). The general pressure in health services to measure service provision for quality and cost-effectiveness has been felt within the hospice movement (op. cit.:1370). Echoing concerns expressed by some of my respondents, James and Field also draw attention to changes in the type of staff now applying to work in hospices. In contrast to the sense of "calling" which drew nurses in the early days of the modern hospice movement, they suggest, nurses are now entering hospices "for employment or

career purposes" (op. cit.:1372). James and Field also observe an increasing tendency for hospices to become more "medicalised", as evidenced by "the formal career based development of doctors specialising in palliative medicine" (op. cit.: 1373). These changes represent very real challenges to the nurses' identities as hospice nurses. If the ethos of hospice care is eroded more and more, the point of balance they have achieved through a sometimes lengthy process of searching for congruence between personal values and ideals of care and working environments in which it is possible to live out these values and ideals will be seriously threatened.

Rasmussen et al (1995:353) observe that, for most of the hospice nurses in their study "nursing care becomes meaningful, once one is permitted to act in accordance with one's own values and outlook in life." The nurses in my own study made very clear, through their descriptions of the ways in which they wanted to nurse and the obstacles they faced in putting their ideals into practice in the NHS, that, in the hospice environment they had found the opportunity to practise 'meaningful' nursing. They had "refound" nursing, and in so doing, had become 'authentic' beings in Heidegger's terms - they were able to be the nurses they had sought to become and the people they knew themselves to be (Heidegger 1973).

Making sense of one's self

Seeking to answer my research questions

In any qualitative research, I suggest, the questions one sets out to answer (which must be formulated at an early stage in one's journey of exploration) can only ever act as very large-scale maps to guide the research. The questions I set out to answer at the beginning of my journey certainly demand to be answered, but I suggest that the answers mean little unless considered in the context of the whole 'story' my respondents and I co-constructed through the research.

Are experiences of caring for others, personal health problems and bereavement seen as influential in bringing people to work as hospice nurses (as suggested by Mason 2002)?

Previous studies have frequently found that different types of personal experience (e.g. of health problems or caring) are cited as having influenced individuals to become nurses (see Chapter 2

and Appendix 2). While some of the nurses I interviewed did make sense of their choice of hospice work in terms of personal experience of caring, health problems or bereavement, this was not by any means true for all, and many other factors were identified as having moved individuals towards becoming first nurses and then hospice nurses.

What are the perceived patterns of interaction between the factors that influence people to become hospice nurses (for example, are some types of influence accorded primacy over others?)

It was not possible to discern clear patterns of interaction between the factors recalled as having influenced the nurses in their career choices, although the influence of family members, role models and schoolteachers in pointing individuals towards some occupations and away from others was recalled particularly frequently. For men, the availability of male role models appeared to have been especially influential and once they had started nurse training, positive role models (nurses who nursed in a way respondents admired) and negative role models (nurses seen to give poor or unacceptable nursing care), hospice placements and 'good' and 'bad' death experiences all helped the nurses to develop and refine their being-towards-care.

Is there any alignment between broad understanding of life purpose/spiritual or religious values and choice of hospice work?

This question reflected my original interest in the possibility of a link between spiritual/religious beliefs and working in a hospice. My interviews with hospice nurses did not indicate any clear link between spiritual/religious beliefs and hospice work (although a few individuals did link their work explicitly with their religious beliefs). Of greater meaning to the nurses to whom I spoke was the importance of ideals and values (the nurses' being-towards-care) and the seeking out of opportunities to care for patients in ways which were acceptable to them. However, in response to the checklist they completed following interview, half of my respondents clearly indicated that "spiritual/religious beliefs" had been strongly influential in bringing them to work in a hospice (see Appendix 8). The discrepancy between these results may suggest that, while spiritual/religious values were meaningful for the nurses and influential in leading some of them seek out hospice

work, the vocabulary of spiritual/religious sentiment is no longer readily available in twentieth-century nursing discourse.

Does 'caring towards death' (rather than 'caring for life') come to be accorded a positive value, and if so, in what way?

The nurses' narratives suggest that caring towards death does come to be accorded a positive value insofar as it enables them (if practised within an 'enabling' environment) to give nursing care which they have identified as "ideal" - that it is, holistic, patient-and family-focused, hands-on nursing care in which it is possible to develop close and rewarding relationships with patients and their families.

What are the features of hospice work that attract nurses and encourage them to continue in this work?

My data suggest that the features of hospice work that attract nurses and encourage them to continue in this work are those which, for them, distinguish between the care it is possible to give in hospices and the care it is possible to give in NHS environments. Adequate funding and high staff: patient ratios mean that nurses have more time to spend with patients, are able to respond quickly to individual patient needs and can develop close emotional relationships with patients.

In what ways do individuals' perceptions, motives and personal stories interact and influence one another in the process of becoming and being a hospice nurse?

In framing this question, my original concern had been to distinguish between *perceptions* of what working in a hospice and in other specialties would involve, *motives* in terms of what individuals had hoped to achieve by making particular choices, and the ways in which individuals construct their own *stories* as a way of making sense of their experience and of relating their current position to a meaningful past. Rather than use the term 'motive' (which I used at the very beginning of my research but quickly abandoned as not a particularly useful and over-psychologised notion) it seems to me that, in the context of this research, the concept of *ideals* is a more useful guide to

understanding, even if the nurses did not use it themselves. It was their ideals and values of nursing - their 'being-towards-care' - which the nurses wished to put into practice, and it was their *perceptions* of the extent to which they could put these into practice in different nursing specialties which made sense of their choices. By telling me their *personal stories*, they were able to explain to themselves and to me the ways in which they had come to seek authenticity by finding a setting in which they could best put their ideals into practice.

Narrative and context

The nurses' retrospective narratives, I suggest, represent their attempts to make sense of and give coherence and meaning to their life paths and maintain their sense of integrity and self value. The confrontation between competing discourses relating to ideals of care, on the one hand, and realities on the other, represents the background against which the nurses had negotiated their individual identities. By setting the nurses' articulations in the context of discourses relating to developments in health care in the twenty first century, we can relate their very personal experiences to societal change, endorsing Heidegger's insistence that, as human beings, we can only understand ourselves in relation to the world we inhabit.

Numerous writers draw attention to concerns that, in the early twenty first century, standards of nursing care in hospitals have fallen to unacceptable levels and, in particular, that compassionate care is hard to find on hospital wards (Allen 2004; Ball and Pike 2007; Chambers and Ryder 2009; Firth-Cozens and Cornwell 2009; Maben and Griffiths 2008). Maben (2008:337) argues that "the pendulum may have swung too far, and cost containment and rationalisation are having a detrimental impact on nurses' ability to deliver care and practise the art of caring. The art of caring does not fit easily into a managerial discourse, where caring may be invisible, marginalised and subordinated." Perhaps the concern with cost-effectiveness, evidence-based practice and outcome measures which is affecting the UK health service is not simply indicative of the way in which economic restrictions are affecting all aspects of life in modern, industrialised societies, but is part of a wider societal change away from personalisation and relationship towards rationality and formality.

Like the nurses in Rasmussen et al's (1995) study, the nurses I talked to emerged as deeply committed to providing high standards of care. In Maben et al's terms (2006/2007) they were 'sustained idealists' for whom the failure of the NHS to allow them to put their ideals into practice had not led them to leave nursing or to adjust their ideals in order to remain in an environment which would not allow them to be true to themselves. They had been uncompromising in their search for an environment in which they could practise their ideal nursing and being a hospice nurse meant being the nurse to which they had aspired.

Implications of the research

The results of my research, I suggest, have considerable implications not only for the ways in which hospice nurses may best be supported in their very valuable work, but also for the future of the nursing profession as a whole and, in particular, for nurse education. In a recent edition of the journal *Nursing Ethics* focusing on end-of-life care, Tschudin (2006:333) observed "Increasingly it is clear that nurses are no longer willing to pay lip service to fine ideals while accepting different standards of practice." Based on articles published in that journal alone, wrote Tschudin, it was clear that "nurses are willing to challenge the status quo." In the NHS, suggested Tschudin, "while the best needs to be the goal for which carers are striving, only the second or even third best can be given" (2006:333).

Concerns about cost-effectiveness, efficiency, measurement and targets pervade today's British health-care environment but are alien to what nurses actually go into nursing to do - to provide high quality, individually-tailored care to patients with whom they can form emotionally intimate relationships.

The mismatch between theory and practice in nursing, suggest Maben et al (2006:475) "has potentially profound implications for morale, job satisfaction and retention". It is, they argue, "essential that the issue of an overstretched workforce be acknowledged". Failure to deal with the problems caused by nurses' inability to put their ideals into practice, they argue "could have seriously deleterious consequences for individuals and the future health of the nursing profession" (ibid).

In the context of a health service struggling to provide good quality care for patients against the reality of severe financial stringency, there would appear to be two main options if we are to prevent widespread dissatisfaction and frustration among nurses, which cannot help but affect patient care. Some have argued that it is time for nursing to accept that it must stop setting unrealistic goals and not, to use the words of one of the nurses in Maben et al's study "set [nurses] up for [a] fall" (2007:103). Allen (2004:271) argues that the nursing profession has "little to gain" by "pursuing an agenda of holistic patient care centred on emotional intimacy" and should instead focus on training nurses as mediators of care, with a mandate to ensure quality of care through supervision of other health care staff. Maben et al (2007:111) while not proposing that nurses abandon their ideals and values, suggest that "Reconceptualising qualified nurses as leaders, advisers, supporters and commissioners of good, high-quality care, as well as knowledgeable direct care-givers, would... give the solution to ensuring a continued emphasis on the core values of nursing such as dignity, and holistic, person-centred, individualised care."

Another alternative might be to vigorously challenge levels of health-care funding to ensure that there is a significant reduction in the current theory-practice gap which leads to so much dissatisfaction and stress among nurses. Chambers and Ryder (2009:208) call for a challenge to "inadequate resources that have a negative impact on our caring capacity" while Andrew Lansley, as British Shadow Health Secretary, argued "We have got to get the resources to the frontline and remove the burden of bureaucracy from NHS staff. For nurses, a combination of less central control and more incentives for hospital performance could give them more time to do the job they signed up for - helping patients." (Donnelly 2007).

Looking beyond the restrictions on 'ideal practice' imposed by economic and sociological factors, I suggest that the dilemmas of idealism articulated by the nurses in my study can be seen as existential issues relating to the sense of disenchantment that comes from being human and which cannot necessarily be explained away by reference to economic and social context. They illustrate the struggle all human beings must experience in the search for understanding of what it means to be a self. Perhaps the identities these nurses are pursuing will always be ideals and their attempts to attain these ideals will remain a sober reminder of the struggle of being human. While individual

moments in which the nurses experience meaningful existence (doing a patients' make-up, giving a patient a bed bath) are highlights of their nursing experience, they are, of necessity, transitory.

In the short term, there is a clear need for support to assist newly qualified nurses to accept the realities of working within a cash-strapped health service while maintaining the ideals with which they emerge from training (Beck 2000:322; Chambers and Ryder 2009:192; Maben et al 2006:474). For those who have managed to put their ideals into practice, there is a clear need for continuing staff support and, if changes within UK hospices are not to result in an end to the personal equilibrium the nurses in my study have attained, an urgent need for research to assess the impact of change on hospice nurses' abilities to provide what they see as 'good' nursing care. Further research might also usefully focus on the ways in which ideals and values are taught and formed within current nurse education.

Final thoughts

Through an attempt to understand how nurses attribute meaning to their journeys into hospice work, this thesis has demonstrated the utility of Heidegger's notion of 'being-in-the-world'. By coming to understand the ways in which individuals set their personal narratives in the context of societal factors and engage their dynamic selves in ongoing conversation with themselves and others, this thesis has illustrated that, as individuals, we can only make sense of ourselves by taking account of the world around us.

The phenomenological conversation I have generated and explored in this thesis illustrates the value of seeking not to establish what 'actually happened' in individuals' lives, but to reach understanding of the meanings individuals attribute to their life experiences and the ways in which they utilise these meanings to establish personal identity.

References

Ablett J and Jones R (2007) Resilience and well-being in palliative care staff: A qualitative study of hospice nurses' experience of work. *Psycho-oncology* 16 (8): 733-740.

Adejunmobi A (1986) Socio-demographic characteristics and opinions of basic and post-basic nursing students in Nigeria. *International Journal of Nursing Studies*, 23(4): 337-347.

Allen D (2001) *The changing shape of nursing practice: The role of nurses in the hospital division of labour*. London: Routledge.

Allen D (2004) Re-reading nursing and re-writing practice: Towards an empirically based reformulation of the nursing mandate. *Nursing Inquiry*, 11 (4): 271-283.

Allen D and Hughes D (2002) *Nursing and the division of labour in healthcare*. Basingstoke: Palgrave Macmillan.

Andrews M, Squire C and Tamboukou M (2008) *Doing narrative research*. London: Sage.

Ball J and Pike G. (2007) *Holding on: Nurses' employment and morale in 2007*. Hove: Employment Research Ltd.

Ball J and Pike G (2009) *Past imperfect, future tense: Nurses' employment and morale in 2009*. Hove: Employment Research Ltd for Royal College of Nursing.

Barnard A, Hollingum C and Hartfiel B (2006) Going on a journey: Understanding palliative care nursing. *International Journal of Palliative Nursing*, 12 (1): 6-12.

Barriball K and While A (1996) The similarities and differences between nurses with different career choice profiles: Findings of an interview study. *Journal of Advanced Nursing*,23: 380-388.

Beck C (1997) Nursing students' experiences caring for dying patients. *Journal of Nursing Education* 26 (9): 408-415.

Beck T (1994) Phenomenology: Its use in nursing research. *International Journal of Nursing Studies*, 31 (6): 499-510.

Beck T B (2000) The experience of choosing nursing as a career. *Journal of Nursing Education*, 39 (7):320-322.

Becker C (1992) *Living and relating: An introduction to phenomenology.* Newbury Park/London/New Delhi: Sage.

Beckford M. (2007) Thousands of nurses still seeking jobs months after qualifying. *Daily Telegraph* 6 July 2007.

Benner P (1984) *From novice to expert: Excellence and power in clinical nursing practice*. California: Addison-Wesley.

Benzein B and Saveman B-I (1998) Nurses' perception of hope in patients with cancer: A palliative care perspective. *Cancer Nursing* 21 (1): 10-16.

Bradshaw A (1996) The spiritual dimension of hospice: The secularisation of an ideal. *Social Science and Medicine*, 43 (3):409-419.

Bradshaw A (1997) The historical tradition of care. In G Brykczynska and M Jolley (Eds) *Caring: The compassion and wisdom of nursing*. London: Arnold: 10-31.

Brasch S (Ed) (2005) *Hospice and palliative care directory: UK and Ireland 2005*. London: Help the Hospices.

Bridges J (1990) Literature review on the images of the nurse and nursing in the media. *Journal of Advanced Nursing*, 15: 850-854.

Brindle D (2004) Fallen Angels? *The Guardian (Society Guardian).* 14 January 2004.

British Broadcasting Association (2007) *You and yours*. BBC Radio 4. 10 July 2007.

British Broadcasting Association (2009) *Any Questions 28 August 2009/Any Answers 29 August 2009*. BBC Radio 4.

British Sociological Association (2002) *Statement of ethical practice for the British Sociological Association March 2002*. www.britsoc.co.uk/bsaweb.php?link_id=14&area=item1 (Accessed 27 January 2005).

Burnard P (1997) Why care? Ethical and spiritual issues in caring in nursing. In G Brykcznska and M Jolley (Eds) *Caring: The compassion and wisdom of nursing*. London: Arnold: 32-44.

Campbell A (1984) *Moderated love: A theory of professional care*. London:SPCK.

Carroll B (2001) A phenomenological exploration of the nature of spirituality and spiritual care. *Mortality*, 6(1): 81-98.

Cassidy S (1988) *Sharing the darkness: The spirituality of caring*. London: Darton, Longman and Todd.

Chambers C and Ryder E (2009) *Compassion and caring in nursing*. Oxford: Radcliffe.

Clarke J and Wheeler S (1992) A view of the phenomenon of caring in nursing practice. *Journal of Advanced Nursing,* 17: 1283-1290.

Cohen J, Palumbo M, Rambur B and Mongeon J (2004) Middle school students' perceptions of an ideal career and a career in nursing. *Journal of Professional Nursing*, 20 (3): 202-210.

Cohen M, Kahn D and Steeves R (2000) *Hermeneutic phenomenological research: A practical guide for nurse researchers*. Thousand Oaks/London/New Delhi: Sage.

Colaizzi P (1978) Psychological research as the phenomenologist views it. In R Valle (Ed) *Existential phenomenological alternatives for psychology*. New York: Oxford University Press: 48-71.

Collings J (1997) People choose nursing for love, not money. *Nursing Times*, 93(31): 52-54.

Condon E (1992) Nursing and the caring metaphor: Gender and political influences on an ethics of care. *Nursing Outlook*, 40 (1):14-19.

Copp G (1997) Patients' and nurses' constructions of death and dying in a hospice setting. *Journal of Cancer Nursing*, 1(1): 2-15.

Crotty M (1996) *Phenomenology and nursing research.* South Melbourne, Australia: Churchill Livingstone.

Daily Telegraph (2009) *Poor nursing care must not be tolerated*. Editorial. 28 August 2009.

Davies C (1995) *Gender and the professional predicament in nursing*. Buckingham: Open University Press.

Davies C A (1999) Reflexive ethnography: A guide to researching self and others. London: Routledge.

Day R, Field P, Campbell I and Reutter L. (1995) Students' evolving beliefs about nursing: From entry to graduation in a four-year baccalaureate programme. *Nurse Education Today*, 15:357-364.

Degazon C E and Shaw H K (2007) Urban high school students' perceptions of nursing as a career choice. *Journal of National Black Nurses Association*, 18 (1): 8-13.

Department of Health (2007) *2006 NHS workforce survey*. www.ic.nhs.uk/webfiles/publications/nhsstaff2006/non-med/Table%203.xls (Accessed 13 December 2007).

De Vries K (2000) *Case study on how role-models influence palliative care nurses in their choice of career*. Unpublished M Sc thesis, University of Surrey.

De Vries K (2007) *Computer assisted software in analysis of qualitative data (CAQDAS) versus manual analysis*. PowerPoint presentation. Guildford, Surrey: European Institute of Health and Medical Sciences, University of Surrey.

Dobratz M C (1990) Hospice nursing: Present perspectives and future directives. *Cancer Nursing*, 13(2): 116-122.

Donnelly L (2007) Nurses spend less than half shift with patients. *Sunday Telegraph*. 22 April 2007.

Dunniece U and Slevin E (2002) Giving voice to the less articulated knowledge of palliative nursing: An interpretative study. *International Journal of Palliative Nursing*, 8(1): 13-20.

Ellis C (2004) The *ethnographic I: A methodological novel about autoethnography.* California: Altamira Press.

Ellis S (1997) Patient and professional centred care in the hospice. *International Journal of Palliative Nursing*, 3(4): 197-202.

Ersser S J (1997) *Nursing as a therapeutic activity. An ethnography*. Aldershot: Avebury.

Fenush J K and Hupcey J E (2008) An investigation of clinical unit choices by graduating baccalaureate nursing students. *Journal of Professional Nursing*, 24 (2): 90-95.

Festinger L (1957) *A theory of cognitive dissonance*. London: Tavistock.

Field D (1989) *Nursing the dying*. London: Tavistock/Routledge.

Firth-Cozens J and Cornwell J (2009) *The point of care: Enabling compassionate care in acute hospital settings*. London: The King's Fund.

Fisher M (1996) How do members of an interprofessional clinical team adjust to hospice care? *Palliative Medicine*, 10: 319-328.

Fleming V, Uta G and Robb Y (2003) Hermeneutic research in nursing. Developing a Gadamerian-based research method. *Nursing Inquiry*, 10 (2):113-20.

Gadamer H-G (1976) *Philosophical hermeneutics.* (Trans. D Linge). Berkeley: University of California Press.

Gadamer H-G (1988) *Truth and method*. London: Sheed and Ward.

Gadamer H-G (1989) *Truth and method*. (2nd revised edition) (Trans. J Weinsheimer and D Marshall). London: Sheed and Ward.

Gadamer H-G (1990) *Wahrheit und methode:Grundzuge einer philosophischen hermeneutic*. Tubingen:J C B Mohr (cited in Fleming et al 2003).

Gardham D (2006) No nursing jobs for students at end of training. *Daily Telegraph* 30 June 2006.

Gaydos H L (2004) The living end: Life journeys of hospice nurses. *Journal of Hospice and Palliative Nursing*, 6(1): 17-26.

Giddens A (1976) *New rules of sociological method*. London: Heinemann.

Giorgi A (1985) *Phenomenology and psychological research*. Pittsburgh, Pennsylvania: Duquesne University Press (cited in Beck 1994).

Grainger P and Bolan C (2006) Perceptions of nursing as a career choice of students in the Baccalaureate nursing program. *Nurse Education Today*, 26: 38-44.

Green J and Thorogood N (2004) *Qualitative methods for health research*. London: Sage.

Grossman D, Arnold L, Sullivan J, Cameron M E and Munro B (1989) High school students' perceptions of nursing as a career: A pilot study. *Journal of Nursing Education* 28(1): 18-21.

Guba E G and Lincoln Y S (1981) *Effective evaluation*. San Francisco: Jossey-Bass (cited in Ersser 1997).

Hallett C (1995) Understanding the phenomenological approach to research *Nurse Researcher,* 3 (2): 55-65.

Hammersley M (1990) *Reading ethnographic research: A critical guide*. London: Longmans (cited in Silverman 1993: 149).

Happell B (1999) When I grow up I want to be a …? Where undergraduate student nurses want to work after graduation. *Journal of Advanced Nursing* 29(2): 499-505.

Harding N (1999) *Nurses' opinions about the use of complementary therapies in palliative care: The contribution to the patient's sense of well-being.* Dissertation submitted as course requirement for M Sc Complementary Therapy Studies, Centre for Community Care and Primary Health, University of Westminster, London.

Harrison J and Burnard P (1993) *Spirituality and nursing practice*. Aldershot: Avebury.

Hart C (2004) *Nurses and politics: The impact of power and practice*. Basingstoke: Palgrave Macmillan.

Heidegger M (1962) *Being and Time* (Trans. Macquarie J and Robinson E) Oxford: Blackwell (cited in Koch 1995).

Heidegger M (1973) *Being and time* (Trans J. Macquarrie and E Robinson). Oxford: Basil Blackwell.

Hemsley-Brown J and Foskett N H (1999) Career desirability: Young people's perceptions of nursing as a career. *Journal of Advanced Nursing*, 29 (6):1342-1350.

Heskins F M (1997) Exploring dichotomies of caring, gender and technology in intensive care nursing: A qualitative approach. *Intensive and Critical Care Nursing*, 13: 65-71.

Hollway W and Jefferson T (2000) *Doing qualitative research differently: Free association, narrative and the interview method*. London: Sage.

Holmes S, Pope S and Lamond D (1997) General nurses' perceptions of palliative care. *International Journal of Palliative Nursing*, 3 (2): 92-99.

Hopkinson J B, Hallett C E and Luker K A (2003) Caring for dying people in hospital. *Journal of Advanced Nursing*, 44 (5): 525-533.

Hunter B (2005) Emotion work and boundary maintenance in hospital based midwifery. *Midwifery*, 21:253-66 (cited in Maben et al 2007).

Husserl E (1964) *The idea of phenomenology* The Hague: Martinus Nijhoff .

Husserl E (1970) *Logical investigations* Vols 1 and 2 (Trans. J Finlay) New York: Humanities Press (cited in Moustakas 1994:45).

James N and Field D (1992) The routinization of hospice: Charisma and bureaucratization. *Social Science and Medicine*, 34 (12):1363-1375.

Janesick V J (1998) The dance of qualitative research design: Metaphor, methodolatry, and meaning. In N K Denzin and Y S Lincoln (Eds) *Strategies of Qualitative Inquiry*. London: Sage: 35-55.

Kagan S H (2009) Foreword. In C Chambers and E Ryder *Compassion and caring in nursing.* Oxford: Radcliffe: vii-ix.

Kalideen D (1994) Why nurses choose theatre nursing. *British Journal of Theatre Nursing*, 3(10):16-25.

Kalisch B J and Kalisch P A (1983a) Anatomy of the image of the nurse: Dissonant and ideal models. In C A Williams (Ed) *Image-making in nursing*. Kansas City: American Academy of Nursing: 3-21.

Kalisch B J and Kalisch P A (1983b) Improving the image of nursing. *American Journal of Nursing*, 1: 48-54.

Kersten J, Bakewell K and Meyer D (1991) Motivating factors in a student's choice of nursing as a career. *Journal of Nursing Education*, 30 (1): 30-33.

Kiger A M (1993) Accord and discord in students' images of nursing. *Journal of Nursing Education*, 32 (7): 309-17.

Klemm D (1983) *The hermeneutical theory of Paul Ricoeur: A constructive analysis*. London and Toronto: Associated University Presses.

Koch T (1995) Interpretive approaches in nursing research: The influence of Husserl and Heidegger. *Journal of Advanced Nursing*, 21: 827-836.

Koch T (1999) An interpretive research process: Revisiting phenomenological and hermeneutical approaches. *Nurse Researcher*, 6 (3): 20-34.

Kohler P A and Edwards T A (1990) High school students' perceptions of nursing as a career choice. *Journal of Nursing Education*, 29(1): 26-30.

Kvale S. (1996) *InterViews: An introduction to qualitative research interviewing*. London: Sage.

Larkin P (1998) The lived experience of Irish palliative care nurses. *International Journal of Palliative Nursing,* 4 (3):120-126.

Lush S (1991) *Trinity Hospice: A history of care 1891 – 1991*. London: Trinity Hospice.

Maben J (2008) The art of caring: Invisible and subordinated? A response to Juliet Corbin: 'Is caring a lost art in nursing?' *International Journal of Nursing Studies*, 45: 335-338.

Maben J and Griffiths P (2008) *Nurses in society: Starting the debate*. London: National Nursing Research Unit, King's College London.

Maben J, Latter S and MacLeod Clark J (2006) The theory-practice gap: Impact of professional-bureaucratic work conflict on newly-qualified nurses. *Journal of Advanced Nursing*, 55: 1-13.

Maben J, Latter S. and MacLeod Clark J (2007) The sustainability of ideals, values and the nursing mandate: Evidence from a longitudinal qualitative study. *Nursing Inquiry*, 14 (2): 99-113.

Mackay L (1989) *Nursing a problem*. Milton Keynes: Open University Press.

Mackintosh C (2007) Making patients better: A qualitative descriptive study of registered nurses' reasons for working in surgical areas. *Journal of Clinical Nursing*, 16:1134-1140.

Maeve M K (1998) Weaving a fabric of moral meaning: How nurses live with suffering and death. *Journal of Advanced Nursing*, 27: 1136-1142.

Marriner-Tomey A, Schwier B, Marticke N and Austin J (1990) Sophomore high school students' perceptions of ideal and nursing career choices. *Nursing Forum*, 25: 27-30 (cited in Marriner-Tomey et al 1996).

Marriner-Tomey A, Schwier B, Marticke N and May F (1996) Students' perceptions of ideal and nursing career choices. *Nursing Outlook*, 44: 27-30.

Marshall C and Rossman G (1999) *Designing qualitative research*. Third edition. London: Sage.

Marsland L and Hickey G (2003) Planning a pathway in nursing: Do course experiences influence job plans? *Nurse Education Today*, 23: 226-235.

Marvin G (2006) Research, representations and responsibilities: An anthropologist in the contested world of foxhunting. In S Pink *Applications of anthropology: Professional anthropology in the twenty-first century*. New York: Berghahn Books:191-208.

Mason C (ed) (2002) *Journeys into Palliative Care: Roots and Reflections.* London: Jessica Kingsley.

May E, Champion V and Austin J K (1991) Public values and beliefs towards nursing as a career. *Journal of Nursing Education*, 30 (7): 303-310 (cited in De Vries 2000).

McCartney J (2008) The angels who fell from grace. *Sunday Telegraph,* 2 March 2008.

McNamara B, Waddell C and Colvin M (1995) Threats to the good death: The cultural context of stress and coping among hospice nurses. *Sociology of Health and Illness*, 17(2): 222-244.

McSherry W (2000) *Making sense of spirituality in nursing practice: An interactive approach*. Edinburgh: Churchill Livingstone.

Meadus R J and Twomey J C (2007) Men in nursing: Making the right choice. *Canadian Nurse*, 103 (2):13-16.

Melia K. (1987) *Learning and working: The occupational socialization of nurses*. London: Tavistock.

Mendez D and Louis M (1991) College students' image of nursing as a career choice. *Journal of Nursing Education*, 30(7): 311-319.

Mignor D, Cadenhead G and McKee A (2002) High school counselors' knowledge of professional nursing as a career option. *Nursing Education Perspectives*, 23 (2): 86-88 (cited in Cohen et al 2004).

Mishler E G (1986) *Research interviewing: Context and narrative*. Cambridge, Massachusetts and London, England: Harvard University Press.

Mitchell T (2002) *Becoming a nurse: A hermeneutic study of the experiences of student nurses on a Project 2000 course*. Aldershot: Ashgate.

Moir J and Abraham M (1996) Why I want to be a psychiatric nurse: constructing an identity through contrasts with general nursing. *Journal of Advanced Nursing*, 23: 295-298.

Moores B, Singh B B, Tun A (1983) An analysis of the factors which impinge on a nurse's decision to enter, stay in, leave or re-enter the nursing profession. *Journal of Advanced Nursing*, 8: 227-235.

Moran D (2000) *Introduction to phenomenology.* London and New York: Routledge.

Morse J (1998) Designing funded qualitative research. In N Denzin and S. Lincoln (Eds) *Strategies of qualitative inquiry*. London: Sage: 56-85.

Moustakas C (1994) *Phenomenological research methods*. Thousand Oaks/London/New Delhi: Sage.

Murray M and Chambers M (1990) Characteristics of students entering different forms of nurse training. *Journal of Advanced Nursing*, 15: 1099-1105.

Murrells T, Robinson S and Marsland L (1995) Deciding to pursue nurse education: Sources of information, influence and encouragement. *Nurse Education Today*, 15: 397-405.

Palmer K (1991) How hospice nursing helped me choose nursing. *Imprint*, 38(1): 35-36.

Patton M Q (1990) *Qualitative evaluation and research methods*. London: Sage (cited in De Vries 2000).

Payne S, Dean S and Kalus C (1998) A comparative study of death anxiety in hospice and emergency nurses. *Journal of Advanced Nursing*, 28(4): 700-706.

Pearcey P A and Elliott B E (2004) Student impressions of clinical nursing. *Nurse Education Today*, 24: 382-387.

Punch M (1994) Politics and ethics in qualitative research. In N Denzin and Y Lincoln (Eds) *Handbook of qualitative research.* London: Sage: 83-97.

Rasmussen B, Norberg A and Sandman P (1995) Stories about becoming a hospice nurse: Reasons, expectations, hopes, and concerns *Cancer Nursing*, 18 (5): 344-354.

Rasmussen B, Sandman P and Norberg A (1997) Stories of being a hospice nurse: A journey towards finding one's footing. *Cancer Nursing*, 20(5): 330-341.

Reinharz S (1983) Experiential analysis: A contribution to feminist research. In G Bowles and B Klein (Eds) *Theories of Women's Studies*. London: Routledge: 162-191.

Reinharz S (1992) *Feminist methods in social research*. New York: Oxford University Press.

Ricoeur P (1976) Interpretation theory: Discourse and the surplus of meaning. Fort Worth, Texas: Texas Christian University Press.

Riessman C K (1993) *Narrative analysis*. Sage University Paper: Qualitative Research Methods Series 30. California: Sage.

Roberts J and Barriball K L (1999) Education for nursing: Preparation for professional practice. In I Norman and S Cowley (Eds) *The changing nature of nursing in a managerial age*. Oxford: Blackwell Science: 123-149.

Rognstad M (2002) Recruitment to and motivation for nursing education and the nursing profession. *Journal of Nursing Education*, 41: 321-325 (cited in Fenush and Hupcey 2008).

Rognstad M K, Aasland O and Granum V (2004) How do nursing students regard their future career? Career professions in the post-modern society. *Nurse Education Today*, 24: 493-500 (cited in Fenush and Hupcey 2008).

Rosser M and King L (2003) Transition experiences of qualified nurses moving into hospice nursing. *Journal of Advanced Nursing*, 43(2): 206-215.

Rossiter J-C, Foong A and Chan P-T (1999) Attitudes of Hong Kong high school students towards the nursing profession. *Nurse Education Today*, 19: 464-471.

Salvage J (1985) *The politics of nursing*. London: Heinemann.

Samarel N (1991) *Caring for life and death*. New York: Hemisphere.

Sanders C (2003) Application of Collaizi's method: Interpretation of an auditable decision trail by a novice researcher. *Contemporary Nurse,* 14: 292-302.

Savage J (1995) *Nursing intimacy: An ethnographic approach to nurse-patient interaction*. London: Scutari.

Seago J A, Spetz J, Alvardo A, Keane D and Grunbach K. (2006) The nursing shortage: Is it really about image? *Journal of Healthcare Management*, 51 (2): 96-108.

Sheridan D (2009) E-mail to members of Mass Observation discussion list 20 July 2009.

Silverman D (1993) *Interpreting qualitative data: Methods for analysing talk, text and interaction*. London: Sage.

Spinelli E (1989) *The interpreted world: Introduction to phenomenological psychology.* London/Thousand Oaks/New Delhi: Sage.

Spouse J (2000) An impossible dream? Images of nursing held by pre-registration students and their effect on sustaining motivation to become nurses. *Journal of Advanced Nursing*, 32 (3): 730-739.

Stanley L and Wise S (1993) *Breaking out again: Feminist ontology and epistemology*. London: Routledge.

Steedman P H (1991) On the relations between seeing, interpreting and knowing. In F Steier (Ed) Research and reflectivity. London/Thousand Oaks/New Delhi: Sage: 53-62.

Stevens J A and Crouch M (1995) Who cares about care in nursing education? *International Journal of Nursing Studies,* 32 (3): 233-242 (cited in Happell B 1999).

Stevens K A and Walker E A (1993) Choosing a career: Why not nursing for more high school seniors? *Journal of Nursing Education*, 32(1): 13-17.

Stewart D and Mickunas A (1974) *Exploring phenomenology: A guide to the field and its literature*. Chicago: American Library Association.

Taylor B, Glass N, McFarlane J and Stirling C (1997) Palliative nurses' perceptions of the nature and effects of their work. *International Journal of Palliative Nursing*, 3 (5): 253-258.

Tremayne P (2003) Dying to care? *Nurse 2 Nurse*, 3 (7): 16-17.

Tschudin V (2006) Editorial. *Nursing Ethics* 13 (4):333-334.

Vachon M (1987) *Occupational stress in the care of the critically ill, the dying and the bereaved*. New York: Hemisphere.

Van der Zalm J and Bergum V (2000) Hermeneutic phenomenology: Providing living knowledge for nursing practice. *Journal of Advanced Nursing* 31 (1): 211-218.

Van Kaam A (1966) *Existential foundations of psychology*. Pittsburgh, Pennsylvania: Duquesne University Press (cited in Beck 1994).

Vanhanen L and Janhonen S (2000a) Changes in students' orientations to nursing during nursing education. *Nurse Education Today*, 20: 654-661.

Vanhanen L and Janhonen S (2000b) Factors associated with students' orientations to nursing. *Journal of Advanced Nursing*, 31 (5): 1054-1062.

Walters A (1995) The phenomenological movement: Implications for nursing research. *Journal of Advanced Nursing,* 22: 785-790.

Webster J and Kristjanson L (2002a) "But Isn't It Depressing?" The Vitality of Palliative Care. *Journal of Palliative Care*, 18 (1): 15-24.

Webster J and Kristjanson L J (2002b) Long-term palliative care workers: More than a story of endurance. *Journal of Palliative Medicine*, 5(6): 865-875.

White J (1999) The impact of clinical experience during preregistration diploma in nursing courses on initial career choice. *Journal of Nursing Management*, 7(3):157-165.

Whitehead E, Mason T and Ellis J (2007) The future of nursing: Career choices in potential student nurses. *British Journal of Nursing*, 16 (8): 491-496.

Williams B, Wertenberger D H and Gushuliak T (1997) Why students choose nursing. *Journal of Nursing Education*, 36 (7): 346-348.

Woodward J (2007) Book review: M A Saunders Nearing death awareness: A guide to the language, visions and dreams of the dying. Jessica Kingsley. In *Leveson Newsletter* Issue 18 (November 2007). Knowle, Solihull: Leveson Centre for the Study of Ageing, Spirituality and Social Policy.

Wright D (2002) Researching the qualities of hospice nurses. *Journal of Hospice and Palliative Nursing*, 4(4): 210-216.

Yang M-H and Mcilfatrick S (2001) Intensive care nurses' experiences of caring for dying patients: A phenomenological study. *International Journal of Palliative Nursing*, 7 (9): 435-441.